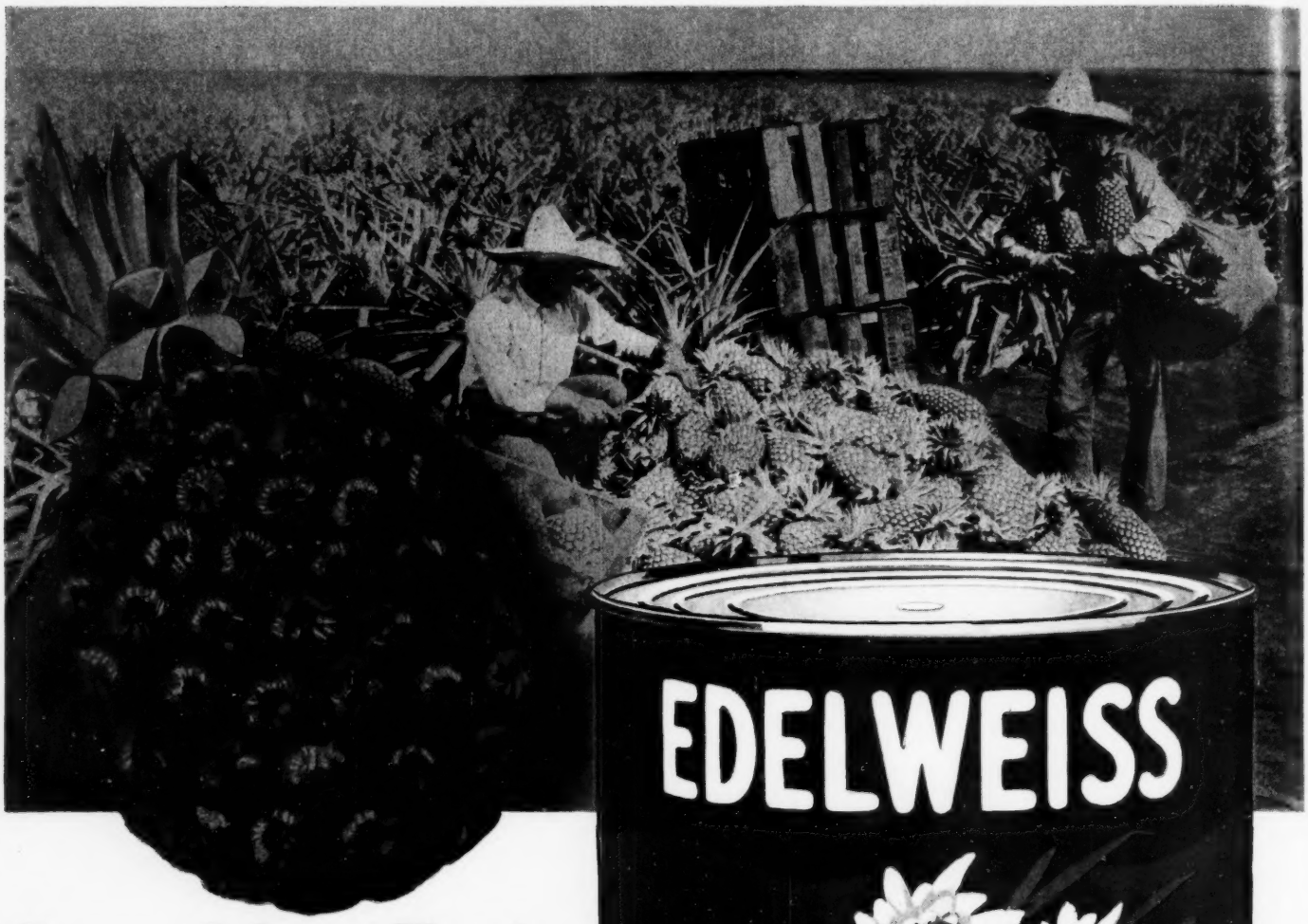
The MODERN HOSPITAL

Volume 44 MAY, 1935 No. 5



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CONTENTS

For May, 1935

Just in Passing—

FAMOUS della Robbia bambinos decorate the arches of the Hospital of Santa Maria degli Innocenti, Florence, shown on our cover this month, familiarly known as the Children's Hospital. The hospital was founded in the year 1400 for the care and protection of foundlings. The custodial institutional care which characterized the hospital for several centuries has in recent years been replaced by definite methods of medical and surgical treatment and formula feeding supervised by the best pediatricians of Italy. The patrons who started this work were the guild of silk merchants and the beautiful hospital they erected, noted for its della Robbia bas-reliefs, draws the tourist to Florence with as keen an interest as the Madonnas of Raphael and the frescoes of Fra Angelico. Visitors from every country as they come into the piazza on which the hospital stands, exclaim, "There are the bambinos," and their faces lighten as they look upon something they have always known and loved.

NATIONAL Hospital Day is again upon us and hospitals in the United States and in many other countries are planning its observance with open house, baby reunions, and special "stunts" of various kinds. A few hospitals will probably take this opportunity to discuss the broader significance of hospital service and to evaluate for their own communities the adequacy of this service. Such institutions will be particularly interested in Doctor Goldwater's campaign for adequate care of the chronic sick, inaugurated with the radio address printed in this month's issue. National Hos-

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pital Day would be an appropriate time to call the community's attention to this long neglected problem.

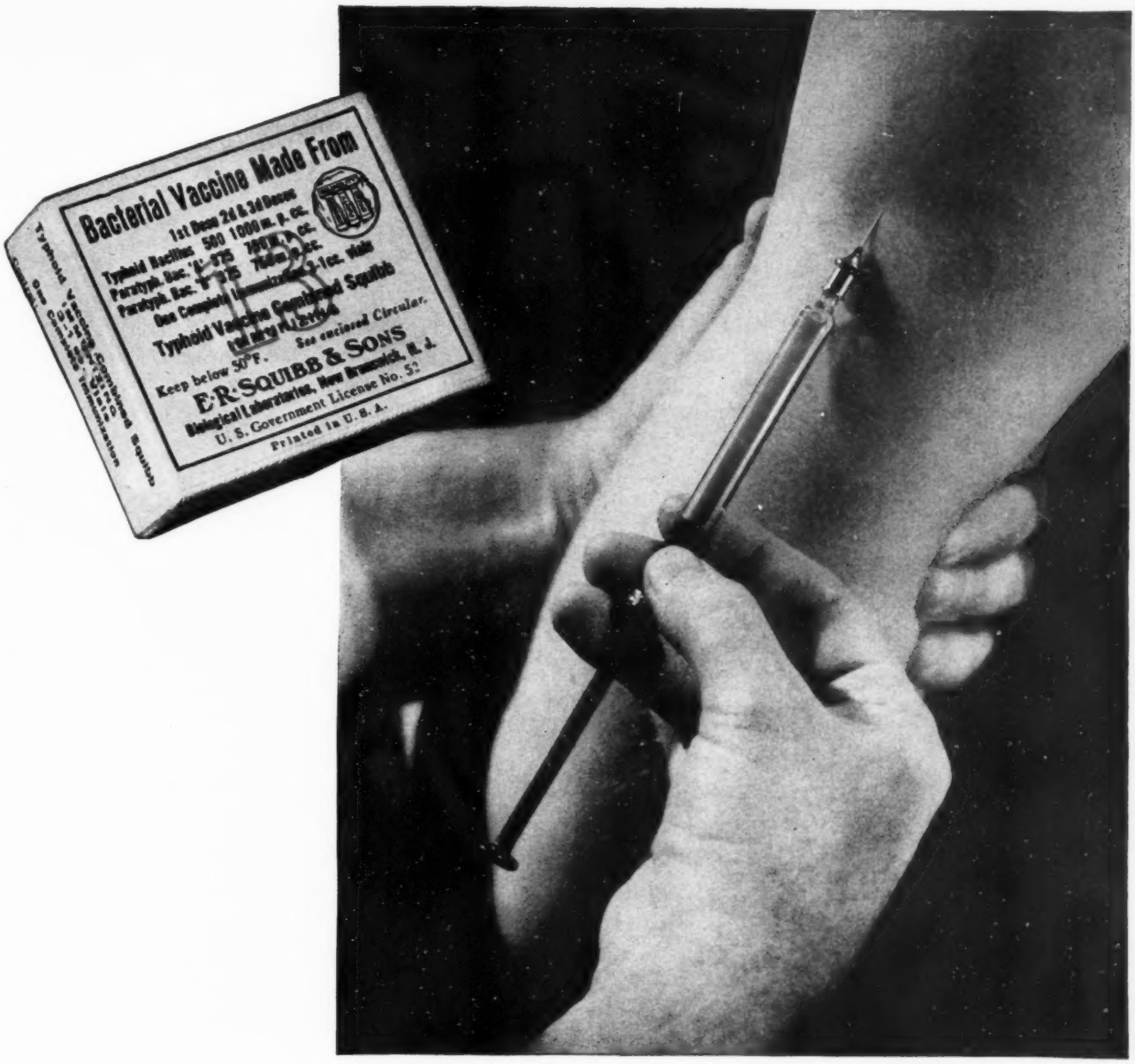
CALIFORNIA'S position as a leader in the movement to provide adequate health service to all is not pure accident. A forward-looking group of hospital and medical people have been seriously concerned with the problem for several years. Four attempts made to solve the problem through the provision of part-pay services are described in the leading article in this issue and the reasons why they failed to do the job are carefully outlined. Next month the director of the medical-economic survey conducted by the California Medical Association will outline the principal findings of this study which were partly responsible for the recent endorsement of health insurance by the association. Townsendism and oranges aren't the only things coming out of California these days!

IS THE use of state tax funds to pay for the hospital care of indigent patients an unmixed blessing, either to the hospitals or the state? Evidently it has raised some problems in Pennsylvania, where it has been most extensively developed. A special commission appointed by the former governor to study the situation recently made a comprehensive report on the subject. While the turn of the political wheel may mean that its recommendations are disregarded in Pennsylvania, their careful analysis will be of value to other states. A digest of the report will appear next month.

THIS question of plumbing hazards in hospitals is arousing nationwide interest. Surveys of hospitals and other quasi-public buildings are being made by health departments of various cities. The second article in the series from the Chicago Board of Health will be published next month.

A NEW column is scheduled to appear shortly in The MODERN HOSPITAL. It will be devoted

CONTENTS



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to a review of events of the month of interest to dietitians. Informal but accurate, we predict your dietitian will soon be "swiping" your copy of the magazine if you don't pass it on promptly. Perhaps you had better subscribe for an extra copy for her now.

CARE of maternity patients is receiving unusual attention nowadays. Stimulated perhaps by the criticisms of those who hold that America's maternal mortality rates are disgraceful, much effort is being expended by both hospital and medical organizations to bring down the rates. But the cost is another question. Both government and voluntary hospitals will be interested in studying the article next month describing the experiment in four-day maternity service which is being conducted at the Alameda county hospitals. It reduces costs without apparently adversely affecting mortality. At present the subject is controversial.

FLASHES FROM THIS ISSUE:

"That hospital which does not take into full consideration the new intern's inexperience, his abject terror of being required to assume responsibility for which he is not prepared is falling far short of properly planning for a well rounded training course." *Page 73.*

"Boards of trustees should make a canvass of all possibilities of refinancing any capital debts now burdening their hospitals." *Page 54.*

"Physicians testify that with contagious diseases under effective control and mothers constantly acquiring an increasing mastery of the hygiene of infancy and childhood, private practice is becoming more and more an affair of the treatment of chronic diseases." *Page 65.*

"The general principle of part-pay care is not new. It is a time-honored tradition of private physicians to grade fees to patients' incomes." *Page 40.*

"The thoughtful superintendent of today realizes that the hospital for the mentally ill, more specifically the state hospital, is inevitably linked with the general hospital as a vital center of community interest." *Page 41.*

THE MODERN HOSPITAL

THE MODERN HOSPITAL PUBLISHING CO., INC.
OTHO F. BALL, M.D., *President*
919 NORTH MICHIGAN, CHICAGO, ILLINOIS

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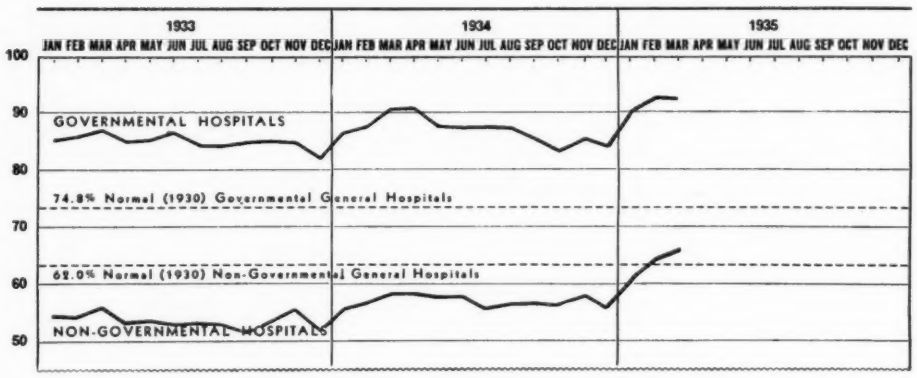
The Hospital Barometer

A distinct rise in occupancy in nongovernmental general hospitals in March carried the occupancy figures seven points above the corresponding figure for 1934 and well above the average for the year 1930. March was the best hospital month for over two years. Governmental hospitals recorded almost the same occupancy as in February. Their occupancy, however, had increased in January and February to new high levels.



Hospital building projects reported from March 12 to April 8 inclusive numbered 17, of which 2 were nurses' homes, 4, new hospitals and 11, additions to hospitals. Of these, 15 reported costs which totaled $1,579,554, an average of $105,300 per project.

Further improvement in business conditions was shown in March and the first half of April, according to the National Industrial Conference Board. The continued expansion of the automobile industry and the sharp rise in building activity were responsible. Output of bituminous coal also rose during March, but a decline set in during the first part of April. The board estimated the number of unemployed in March at 9,760,000 as compared with 9,885,000 in February and 9,394,000 in March of last year. The cost of living of wage earners remained the same in March as in February, according to the board.

Average wholesale prices continued to rise from the middle of March to the middle of April, the composite index of the *New York Journal of Commerce* going from 78.4 on March 16 to 80.3 on April 13, the highest point reached since 1933. In the following week, however, the index fell slightly to 79.9 and further advances were not expected. Grain prices made the most startling advances during the period under review, the index advancing from 82.8 to 91.3. General food prices rose from 79.9 to 83.2, textiles from 59.9 to 61.2 and fuel from 76.5 to 77.4 (all indexes based on 1927-1929 as 100.) Building material prices remained practically unchanged. The price index of drugs and fine chemicals advanced from 186.6 on March 18 to 189.1 on April 22, according to the *Oil, Paint and Drug Reporter*.

During the four weeks ending April 13 the U. S. Public Health Service reported the following cases of communicable diseases: diphtheria, 2,293; influenza, 8,744; measles, 145,440; meningococcus meningitis, 664; poliomyelitis, 84; scarlet fever, 32,035; smallpox, 775, and typhoid fever, 501. As compared with the corresponding period of last year there were increases for influenza, measles, meningitis, scarlet fever and smallpox and decreases for the others.

Occupancy Figures of Hospitals in Various States and Cities

Type and Place	*Census Data on Reporting Hospitals*[1]		*1934*										*1935*		
	Hospitals	*Beds*[2]	*Mar.*	*April*	*May*	*June*	*July*	*Aug.*	*Sept.*	*Oct.*	*Nov.*	*Dec.*	*Jan.*	*Feb.*	*March*
Nongovernmental															
New York City[3]	68	15,194	73.0	75.0	75.0	75.0*	66.0	62.0	61.0	66.0	68.0	66.0	70.0	70.0*	70.0*
New Jersey	58	9,772	63.0	63.0	63.0	61.0	61.0	59.0	58.0	60.0	61.0	58.0	62.0	65.0	65.0*
Washington, D. C.	9	1,782	67.2	65.8	62.8	62.8	58.4	59.3	60.7	65.4	65.3	61.8	72.0	71.8	70.5
N. & S. Carolina	99	5,779	59.2	59.4	59.6	62.1	62.6	62.3	60.9	61.1	60.9	56.8	60.6	63.1	64.9
New Orleans	7	1,196	46.5	42.1	43.2	48.4	43.3	52.1	49.5	49.5	47.7	44.9	47.7	49.5	50.3*
San Francisco	16	3,026	61.9	61.6	60.3	58.1	56.8	56.9	60.8	64.2	63.2	62.0	65.5	68.2	67.4
St. Paul	6	912	49.4	50.7	47.3	49.1	44.9	45.7	43.4	39.1	45.8	45.8	41.5	53.6	53.6*
Chicago	22	5,847	53.3	55.4	56.5	57.7	57.3	59.3	55.6	56.9	57.9	54.5	57.4	57.3	61.9
Cleveland	9	2,240	58.0	61.8	59.9	61.3	60.0	58.4	56.7	57.8	57.7	56.5	61.9	62.0	61.2
Total[4]	294	45,748	59.1	59.4	58.6	59.5*	56.8	57.2	56.3	57.7	58.6	56.3	59.8	63.4*	66.1*
Governmental															
New York City	16	11,615	105.0	103.7	101.9	93.7	91.3	89.5	88.3	89.4	91.0	92.9	96.7	100.6	103.2
New Jersey	6	2,122	93.0	91.0	90.0	86.0	85.0	80.0	80.0	83.0	81.0	78.0	86.0	86.0	86.0*
Washington, D. C.	2	1,076	83.2	84.3	84.7	84.7	79.0	80.2	81.7	78.1	84.8	77.6	86.6	95.5	95.5
N. & S. Carolina	12	1,241	66.4	66.8	64.5	69.4	70.6	66.9	64.0	67.0	68.3	64.7	65.4	65.7	68.5
New Orleans	2	2,227	129.5	136.4	127.1	137.9	148.7	152.4	148.0	129.3	131.6	130.5	144.9	145.4	130.4
San Francisco	3	2,315	79.2	76.7	80.7	77.7	76.4	77.9	74.4	72.7	78.1	74.2	77.4	79.1	77.1
St. Paul	1	1,050	76.9	76.3	76.1	73.2	69.0	68.0	67.3	66.8	68.5	68.8	68.8*	78.7	78.7*
Chicago	2	3,790	93.2	94.6	91.1	87.5	84.8	83.7	83.1	84.8	87.0	84.7	89.0	83.4	93.9
Total[4]	44	25,436	90.8	91.2	89.5	88.8	88.1	87.3	85.9	83.9	86.3	83.9	89.4*	91.8	91.7*

[1]Insofar as possible hospitals for tuberculous and mental patients are excluded as well as hospital departments of jails and other institutions. The census data are for the most recent month. [2]Including bassinets, in most instances. [3]Includes only general hospitals. [4]The occupancy totals are unweighted averages. These averages are used in the chart above. *Preliminary report.

THE MODERN HOSPITAL

A Monthly Journal Devoted to the Construction, Equipment, Administration and Maintenance of Hospitals and Sanatoriums

VOLUME 44 — *May, 1935* — NUMBER 5

Four Experiments in Part-Pay Service

What they signify to those who need and those who give medical care

By MARY ROSS

Associate Editor, *The Survey-Survey Graphic*

CALIFORNIA has swung into the limelight this spring as the state in which all the major professional groups concerned with medical services have expressed official approval of the principle of health insurance and are cooperating with a committee of the California senate which proposes health insurance legislation at the current legislative session.

The annual meeting of the Western Hospital Association in mid-February reiterated that body's approval and declared health insurance of prior importance to unemployment insurance since in usual times illness and accident are largely responsible for loss of work and resulting poverty. On March 3 the house of delegates of the California Medical Association adopted a resolution probably unprecedented in the history of organized medicine. It sponsored the adoption of legislation for insurance, mandatory for certain groups of the population and voluntary for others, under specified principles, and established a committee to cooperate with the senate committee. Similar committees also have been appointed by the Western Hospital Association and the organized dental profession. The California State Nurses Association has approved the principle of health insurance and declares that adequate nursing should be included.

The action of the professions followed two extensive surveys made this year under the auspices of the California Medical Association and the State Emergency Relief Administration which reaffirmed the peculiar difficulties that at all times beset payment of the uneven and unpredictable costs of medical care, and underscored the present particularly difficult plight of patients, professions and institutions. It also follows a long and varied history of experience and experiment with less comprehensive measures dealing with sickness costs. One important item in that record is the effort to meet the problem without the use of the insurance principle, by organized effort at adjusting the charges of doctor, hospital, dentist, nurse and others to the ability of the patient to pay. Proposals of bureaus under the auspices of county medical societies or others are under discussion in various parts of the country at the present time. In this field California's experience probably is unique among the states both in extent and variety.

During a recent stay in the state I had an opportunity to talk with physicians, social workers and others concerned with the work of such plans in San Diego, Pasadena, Santa Barbara and in Ala-

meda County. The central medical service which has been operating for more than two years in San Diego is probably the oldest and most widely quoted of the part-pay plans. Its work originated in a suggestion from the community welfare council.

At the present time administrative expenses are met by a percentage of the fees collected on behalf of doctors and hospitals. Under this plan the medical social worker who directs the service, Mary R. Hughes, is responsible for setting the fee that she deems just to the patient after an investigation of his circumstances. Nearly all the members of the county medical society have agreed to cooperate and accept the social worker's judgment. The county dental society is cooperating on a reduced fee basis. All payments by patients are made to the service, and may be made in installments when the patient can establish credit and gives his note.

Hospitalization is arranged under the following policies:

1. In arranging fees the factor of equal sacrifice on the part of the physician, surgeon, anesthetist and hospital should be the basis of fee setting.
2. The operating cost to the hospital should be met in each case.
3. The central medical service is responsible for a cash payment to both surgeon and hospital for the period of planned care. If the patient remains in the hospital over the planned number of days or uses excessive dressings and pharmacy the central medical service attempts to pay for this at part-pay fees, but can take no legal responsibility for the collection of these unplanned costs.

Charge Should Remain Constant

In its first eighteen months' experience the service averaged 16 per cent over minimum fees on each ten-day surgical case hospitalized, that is, instead of $35 paid to the hospital for a ten-day stay, $41.63 was collected from the patient. "Experience shows us that it is vital to make a charge to the patient that can remain constant," Dr. Hall G. Holder declares in a report of the service in the San Diego Dental Society bulletin. "Part-pay or full-fee patients are eager to know what costs are to be. In the opinion of the secretary of the central medical service, even slightly higher charges are preferred by patients to the uncertainty of medical costs. Patients are willing to pay when they know what they are receiving and when they can budget for it."

During 1933 the service handled 1,350 cases and collected nearly $23,000. In 1934 the cases numbered 1,233 and the collections totaled $33,558, of which $1,885 was paid through federal relief funds. In both years referrals for hospitalization included about 20 per cent of the total number of cases. About 9 per cent of the cases listed in 1934 were referred to physicians at full fees and about 10 per cent referred to county care, while service for 15 per cent still was incomplete at the end of the year. This left approximately 820 completed cases handled under the service for part-pay care. The population of the metropolitan San Diego district is approximately 180,000.

How Pasadena Service Operates

In Pasadena the local medical and dental societies sponsor the central health service, which is supported by registration fees of $1 from patients, memberships of practitioners, and a 10 per cent charge on fees collected. The bureau is in charge of a public health nurse, Mary Ella Stewart, who conducts the social investigation of the patient's circumstances and works out with practitioner and patient the rate to be charged for the needed care. Whenever possible the patient pays cash. All payments are made to the service. Pasadena hospitals are cooperating by giving a 25 per cent deduction to patients referred by the service, which assumes responsibility for the collection of the bill. Payments to hospitals usually are made in advance.

Pasadena has a population of about 80,000. During the first year, ending August, 1934, the service had arranged care for 413 cases, had collected $3,740 for physicians, $2,020 for dentists, $162 for nurses and $1,834 for hospitals. During the six months ending February 1, care was arranged for 340 patients. In the first year 27 per cent of the cases were referred to the office by doctors or dentists; 19 per cent came because of reading newspaper accounts of the work; 12 per cent were referred by the dispensary, and 42 per cent by other agencies, including the school nurses. The service has recently started inserting a notice in the newspapers as a paid advertisement.

Though it had to close April 1, for lack of funds, the community medical service of the Santa Barbara County Medical Society, had made a more rapid start in service than the others. In a city of 40,000 with probably an unusually large group of well-to-do people, it had arranged for care for 1,041 persons in its first ten months. This bureau used a wholly different principle. It did not serve as a collection agency. The medical social worker in charge, Mrs. Clara Griffith, gave each family a financial rating based on its income. Eligibility to the service started at the point at which a person became ineligible for county care, that is, when his income was as much as $50 a month for himself, with an additional $10 for each dependent. It terminated at the point when people were presumed to be able to pay the usual medical charges, or when the income was $150 a month for a single person,

again with the $10 addition for each dependent.

Each accepted applicant received a card on which the family name and financial rating were typed. This was good for three months. During that period a member of the family could go to any of the practitioners or hospitals cooperating in the plan, present the card and receive care at rates definitely scheduled for his income group. These ranged, for example, from $1 for a first office visit and 50 cents for subsequent visits, up to the full rates of $5 and $3 respectively. These last received stipulated rates for operations with a maximum of $75. There were similarly scaled schedules for the various surgical services, x-rays and laboratory services, and for ward care in the hospitals, which was graded from $2 to $3.50 a day. The nurses offered a similar sliding scale of charges. The dentists were working out a fee schedule for patients under the service when I was there. Druggists gave a 20 per cent discount to the group with incomes below $100 a month. The optical company gave them a discount on glasses. If the family needed further service at the end of the three months, they came back for a renewal of the card.

The plan was postulated on the assumption that the family would pay cash to the doctor or hospital; if some other arrangement had to be made, either doctor or hospital had the right to ask higher fees. The cost of running the service was covered by the small registration fee paid by patients when they first used the service, contributions from physicians and a percentage of the first fee received by practitioners from a patient under the plan. Here, also, dignified paid advertising was tried.

Appeals for support to the community chest and other agencies were not granted. Apparently physicians did not feel it brought them sufficient income to warrant continuance.

Policies That Govern Alameda Plan

In the San Francisco Bay region in and about Oakland, the Alameda County Medical Association has assumed responsibility for the care of part-pay patients, and maintains lists of physicians, including practically all its members, who have agreed to care for such patients at whatever rates the family can afford. This society has not established a bureau. The social investigation of the patient's circumstances is made by the out-patient social service department under the county institutions commission. In this connection the supervising medical social worker, Marguerite L. Spiers, is responsible to the secretary of the county medical association. Eligibility for part-pay medical care is determined on a case work basis, according to the following general policies:

Persons considered eligible for part-pay care must be without sufficient resources to pay the full cost of medical care for their present illness; their responsible relatives must be without such resources, and by paying full cost, these persons or their responsible relatives would be deprived of the necessities of life. The term "responsible relatives" is used as defined in the Pauper Act.

Ability to pay a full fee is determined by the illness which the patient has at the time of his application; by his available assets; financial obligations; future earning capacity, and other similar factors.

Who Are Eligible for Part-Pay Care

Those eligible for part-pay care include persons with a margin above the necessities of life. This margin might be sufficient to provide full-pay medical service for some types of illness and insufficient for others.

The ownership of luxuries or unnecessary articles or equipment would render a person ineligible for fee reduction if the market cash value of such things was sufficient to pay the full fee.

If discontinuance of payments on furniture, automobiles or other possessions would release money for full medical fees, the patient would also be considered ineligible for part-pay care.

The procedure used in each case includes an interview with the patient or family; verification of statements of income and assets; communication with the family physician as to his willingness to continue care on the basis of the patient's ability to pay; comparison of income with a minimum cost budget for a family of given size and moderate means, used as a guide only; clearance of the case through the county social service index, and the signing, by the applicant, of a certificate regarding assets and the like. The social worker reports her findings to the physician so that he may have a basis on which to set his fee. If the patient has no private physician he is referred to one on the rotating list of those who have volunteered cooperation through this arrangement.

A study has been made of 1,812 patients referred in 1933 to members of the county medical association for part-pay care. Reports were received from physicians covering 1,304 of these cases. Among those, slightly more than a quarter had not been seen by the physicians to whom they were referred; they must have gone elsewhere or nowhere for care. Of the 969 patients seen by physicians, 233 or 24 per cent had paid nothing in fees; the remaining 736 had paid an aggregate of slightly more than $5,000, an average of a little less than $7 apiece. In that year the total number of cases referred by the county social service to private physicians was 2,077, including five cases for full-

pay care and a number of cases of nonresident indigents referred for unpaid care by volunteering physicians. Figures for 1934 are not yet available; it is believed they will show a somewhat larger number of cases and a somewhat higher total of fees paid. Alameda County has a population of about 400,000 including many industrial workers.

These four experiments in organized part-pay service represent sincere and arduous effort. In each place I talked with physicians who were enthusiastic about their community's plan and with others who opposed it on principle, or were skeptical as to its effectiveness in meeting the problems of those who need and those who give medical services. Lay outsiders, including social workers and members of the public, were, in general, skeptical. They pointed out that the numbers of patients cared for under the plan were extremely small in contrast to those in the community who were unable to pay the usual charges in serious illness. In 1933 more than half the families in the state had incomes under $1,200.

Principle Is Not New

The general principle of part-pay care is not new. It is a time-honored tradition of private physicians to grade fees to patients' incomes. Most hospitals already have their own methods for adjusting charges through their social service departments. In Pasadena, for example, one major hospital had cared for 782 part-pay patients during 1934 among whom fifty-seven were cases referred through the central medical service. The plans systematize the older tradition of the doctor and in some cases make it possible to coordinate the total costs of an illness, bringing together all the bills involved. There was a frequent query in these communities as to whether that approach was sufficient to deal with the real problem.

In most cases this question was coupled with the comment that in general people who were accustomed to pay their way in other departments of life were extremely reluctant to ask for special consideration and reduced rates and to lay all the circumstances of their lives before the eyes even of a friendly and sympathetic social worker. A large number of patients cared for under the plans are near the ragged edge of indigency.

Where a bureau assumes responsibility for collection of charges, as in San Diego or Pasadena, obviously it can extend credit only to families who can prove they are good credit risks. Through no fault of their own many conscientious families are not good credit risks. For this reason these California plans have made little use of installment payments subsequent to the illness.

Where collection is not the responsibility of the bureau there is the question as to whether or not people actually can and will pay more fully and more regularly than under usual methods. In Alameda County nearly a quarter of the patients declared able to pay partial fees actually had paid nothing at all for the care they received during the year studied, and a still larger group had not even gone to the doctor to whom they had been referred.

The more rapid growth of the work in Santa Barbara may have been significant of the fundamentally different principle on which it was based, the definitely arranged schedules of hospital and professional charges, and the fact that a family did not receive particular consideration for a particular illness at a particular time, but was handled in general on the less personal basis of income class.

A pamphlet recently published by the American Medical Association, "Health Insurance in England and Medical Society Plans in the United States," brings together a discussion of the British system and brief accounts of the part-pay plans in San Diego and in Alameda County and the instalment payment plan used by the Wayne County Medical Society, Michigan, of which I have written elsewhere.[1] In conclusion that pamphlet declares that these are "three plans differing widely from health insurance. The medical profession should know well the difference between the two. We can still choose. . . ." Elsewhere in medical circles there is frequent allusion to the work in San Diego or Alameda as an alternative to health insurance.

Criticism Has Been Evoked

Among the persons actually concerned with these plans, and still less among others in those communities, I found little disposition to consider them as such. One physician who whole-heartedly approved the work in his community and was aiding in its direction declared, "This is what the doctors always have done, except that now they can have a social service investigation to help them if they want to." A hospital social worker said, "It still is no help to the patient or to us or to families who cannot pay hospital costs at the time of sickness, and that means most people." I heard a number of caustic comments, including some from physicians, that the upshot of the idea was to provide a collection agency for doctors and why not call it that? The far more general feeling among informed and impartial outsiders, however, was that here was a sincere experiment, significant in the practice in cooperation it provided for professional and lay groups, but not promising as a solution for the basic economic problems of sickness.

[1] Ross, Mary, Sickness Bills by Installment. Survey Graphic: 24: 109, 1935.

Is Postgraduate Work in Psychiatric Nursing Worth the Effort?

By ZELLA N. FRANKLIN, R.N.
Superintendent of Nurses, Toledo State Hospital, Toledo, Ohio

At one time patients in hospitals for the mentally ill were under the care of untrained attendants. Reform movements produced the two-year training school. Now postgraduate schools in psychiatric nursing seem to offer help in this problem in the care of related mind and body illness

POSTGRADUATE courses in psychiatric nursing have been noticeably few. This has been due in large part to the prevailing attitude toward mental diseases and mental nursing but since the World War there has been a drastic change. The medical profession has recognized the fact that diseases of the mind and the body are acutely interdependent. Nurse educators are advocating and devising means of providing experience in mental nursing and postgraduate courses are being organized for this purpose.

In considering the question of postgraduate work in psychiatric nursing, there are several points to be weighed. First, is there a need for nurses specially trained in psychiatric work? A number of years ago in mental hospitals the care of the patient was almost entirely given over to the attendant, who was in most instances neither an educated person nor one who had received any sort of training. As interest was aroused in the care of these patients, there sprang up the two-year schools in mental hospitals, which were organized with the idea of training the individual in the care of patients for a particular institution. As graduates of the two-year school supplanted in large measure the attendant, so the registered nurse is gradually superseding the two-year graduate. Medical science and research have recognzed the need of assistance from a group whose educational requirements must perforce keep in step.

One Nurse to 254 Patients

In 1933 the average daily patient population for all hospitals for mental patients was 474,787. The number of hospitals for mentally ill patients at the same time was 621, making an average daily patient population for each hospital of 764.5. The number of general hospitals for this same period was 4,237, with an average daily patient population of 231,692, or an average daily patient population for each hospital of 54.6. During this same period there were 294,268 registered and student nurses, and of this number 1,870 were employed in the care of mentally ill patients, or one nurse to approximately every 254 patients. The inference is staggering and conclusively answers the question.

The second point to consider is whether or not the hospital has sufficient clinical facilities to offer. Is the patient being given the benefit of the best that science has to offer in laboratory routine, in treatments, in examinations, x-ray, occupation, recreation? If not, or if the care of patients has become only a part of a deadly routine, then the facilities are not sufficient for teaching purposes.

The third point is whether or not the superintendent of the hospital considering such a course, is interested in nursing education. Here the picture again must take on a different aspect from that of former years. The nurse is being educated not for our own use, but for her own use. She may or may not remain in the institution in which she has received her training, but she is being given experience which will be needful and invaluable in whatever type of work she undertakes or in whatever institution she may work.

The thoughtful superintendent of today realizes that the hospital for the mentally ill, more specifically the state hospital, is inevitably linked with the general hospital as a vital center of community interest. In a broader sense must he also realize the hospital as a great teaching center, educating the public, aiding the patients in rehabilitating their lives and offering courses for the training and education of nurses.

It was with these ideas in mind that a three-year school of nursing was organized in the Toledo State Hospital, Toledo, Ohio, in 1930. This at once became the foundation for a postgraduate course.

The three-year school seems a necessity in educating young women whose special interest may be psychiatry, who may be employed as head nurses, supervisors, teachers and administrators, until the general hospital school by means of affiliation undertakes to give every student an opportunity for experience in this work.

A postgraduate course may be one of three types: (1) a refresher or reorientation course, devised to meet the demands of the nurse in general practice, to keep her up to date and in touch with newer ideas and methods in procedure; (2) a supplementary course designed to round out the deficiencies in nursing school preparation; (3) a specialization or advanced course to provide an opportunity for more intensive training on a higher level for nurses wishing to prepare themselves as specialists in one of the various clinical branches.

Since a relatively small percentage of students receive more than a few hours of lectures in psychiatry during training, it seems that the refresher course is ruled out, leaving the supplementary and advanced courses. As the advanced course is designed for more intensive training on a higher level, it should rightfully come under the direction of a university school of nursing. This leaves the supplementary course — a postgraduate course in psychiatric nursing which will provide experience in an important branch of medicine not planned for in the average three-year school.

Living Facilities Are Inadequate

The details of planning such a course in postgraduate work are intricate and puzzling. Requirements of the state medical board and the state board of nurse registration must be met satisfactorily and experience has proved that there are no half-way measures in this regard. Perhaps in our state hospitals the greatest problem is a physical one, that is, the lack of proper living facilities. If the school is to attract the most desirable type of young women, living conditions must be made as attractive as possible and this can be accomplished only by stimulating sufficient interest so that appropriations may be made by the state legislature. The second paramount need is the administrative and teaching personnel of the school. The superintendent of nurses should be a person with previous administrative and psychiatric experience, who is a registered nurse, a college woman, if possible, capable of meeting the demands and requirements of the social, economic and educational world. Her staff must be composed of registered nurses and she should be allowed the freedom and privilege of employing her own personnel. She should also be capable of teaching when necessary, although this should not be demanded of her as administrative duties require her entire time.

The teaching staff should consist, as a minimum, of at least one full-time instructor and one part-time instructor. But in having only the minimum we find too often that we are barely able to meet the minimum requirements set up by the state board of nurse registration and it is best to go beyond these. At Toledo State Hospital we are particularly fortunate in having a full-time instructor, a graduate from our postgraduate school, who has had several years' experience both as an instructor and as superintendent of nurses. The nurse acting as first assistant is also first supervisor and a young woman of exceptional ability. She is a registered nurse and college graduate, who taught for several years before coming here and aside from her duties as supervisor spends several hours a week in the classroom during the school year.

How the Supervisor Serves

Our second assistant, who acts also as supervisor, is a registered nurse and a graduate of our postgraduate school. Her duties are entirely outside the classroom. Believing that the lack of personal supervision over students was one of our weak spots, we were able last year to add a teaching supervisor to our staff. This young woman is also a registered nurse who has had several years' experience as supervisor in a general hospital and some classroom teaching. She is a graduate of our postgraduate school. Her duties are to attend classes so far as possible, at least to keep in close touch with the instructor so that she may follow the student on the floor in her practical procedures, in conferences and in discussions, and stimulate interest and understanding between the nurse and the patient.

Necessarily the work here started slowly. We were not able to place students on floors where a registered nurse was not in charge, but through some adroit changes, we now have registered nurses in charge and students on both medical and surgical floors, the women's receiving hospital, the convalescent floor, the acute psychopathic ward, the suicide ward and the tuberculous ward.

When the postgraduate course was first planned it was designed to cover a period of six months, and although at times it has been a temptation to lengthen it, for a supplementary course the length is sufficient.

Postgraduate students receive experience on each of the above mentioned floors, as well as in

hydrotherapy, occupational therapy and the clinic. During this six months' period, students are on eight-hour duty and cover approximately 148 hours of lecture in the classroom. Subjects covered in the courses are: abnormal psychology, 20 hours; anatomy and physiology of the nervous system, 10 hours; case study, 15 hours; hydrotherapy, 5 hours; psychiatry, 30 hours; psychiatric nursing, including clinics and ward walks, 30 hours; occupational therapy, 6 hours; physiotherapy, 12 hours; mental hygiene, 20 hours; a total of 148 hours.

It is presupposed in accepting students for postgraduate work that they are fundamentally interested in psychiatric nursing; that they have had a thorough foundation in general nursing; that they are registered nurses, having successfully passed the state board examinations in the state in which they were graduated; that they are physically and mentally fit for this type of nursing. Applications, physical records, school records and references are checked before a student is accepted and so far we have been fortunate in that we have had but one real misfit. Several students drop out at the end of a month or six weeks after having decided for themselves that their major interest was not in psychiatric nursing. Classes are entered twice yearly and before the September, 1933, class was formed, eighty-two applications had been received, as well as many inquiries. As the enrollment is limited this gives a wide choice.

Is postgraduate work in psychiatric nursing worth the effort? From the viewpoint of the students, a thousand times yes. Their experience here has proved invaluable to them for they have learned to associate the body and the mind as an entity. One student wrote me not long ago, "Having had this experience I cannot see how any of us could have called ourselves nurses without it."

From the administrative viewpoint, again yes. There have been black days and nights of discouragement, but we are convinced that by virtue of the course our patients are receiving better nursing care, more intelligent supervision and greater understanding than they did previously. The course has been the means of mutual stimulation between the members of the medical staff and the students. The staff has been most generous in giving time to the students in teaching and holding conferences, as well as giving clinics on postmortem examinations, and the students constantly strive to give the physicians the best service. Obviously the patient benefits. The Toledo State Hospital ranks among the best in the United States in its postgraduate work and this speaks well for the effort made.

There is much that we can hope for in expanding the course of study. We do not advocate a postgraduate school in every state hospital for the mentally ill. We do advocate, however, when vacancies occur in the personnel of a state hospital, the employment of registered nurses who have had experience in psychiatric nursing. We hope the future may see a superintendent of nurses in the department of public welfare, whose duties will be to direct and encourage a more adequate, more intelligent, more sympathetic and understanding care of mentally ill patients in all hospitals under its direction. We hope as well to see this nursing service extended for the benefit of men as well as women patients.[1]

[1]Read at the meeting of the Managing Officers Association, Toledo.

Old Lobbies Can Be Improved at Slight Cost

The hospital lobby should be well ventilated, light and spotlessly clean. If insufficient natural lighting is available, artificial lighting from well chosen electric fixtures will suffice, the committee on hospital planning and equipment of the American Hospital Association states. Old wooden floors can be resurfaced or covered with one of the numerous flooring materials.

Badly worn and cracked floors of marble, terrazzo, concrete or tile can probably be most economically and best treated by a covering of linoleum, rubber or composition. Many attractive designs are available in these materials. Before laying a new covering, the old floor should be leveled and all cracks, seams and joints filled with concrete so that the new surface will not present an irregular surface.

A thorough cleaning of marble or tile wainscoting will restore much of the original appearance. The use of strong acid or alkali solutions should be avoided as these attack the finish. Waxing or rubbing with a polishing oil adds luster. Well painted walls of light shades of tan, gray, blue or green are serviceable. The ceiling should be finished in colors that harmonize with the walls, but lighter in intensity. Stenciling or lines on the beams and panels permit effective decorations.

How to Remove Stains

To remove mercurochrome stains wash with ether or acid nitrate or use a solution of alcohol and hydrochloric acid, 5 per cent, according to a reference table in the thirteenth edition of The HOSPITAL YEARBOOK. Properly treated most stains can be removed, particularly if they are cared for promptly. Improperly treated or allowed to stand too long they may be "set" for the life of the goods. A compilation of the best methods of removing forty-three different kinds of stains is presented in the table. These have been compiled from the experience of a number of large hospital and commercial laundries.

What Others Are Doing

Say "Happy Birthday" With a Gift

Does your hospital need dish towels, or food, or sheets, or soap flakes, or even, perhaps, some money? Then have a birthday party. Hillsboro Hospital, Hillsboro, Ill., of which Mrs. Frank I. Clotfelter is superintendent, has a birthday party each year.

On its nineteenth birthday, celebrated in March, about 100 people attended the tea bringing gifts, and many who were kept home because of the stormy weather, sent gifts. Among the presents received were vegetables, dishes, bath and tea towels, sheets, pillow cases, soap, canned fruit, jelly, preserves, dresser scarves, electric light globes, eggs, books, flowers, cheese, milk, bacon, and about $150 which will be used to purchase beds.

The hospital has a thirty-five-bed capacity. During 1934, 435 patients were admitted.

Nursing School Graduates Flock to One-Day Institute

An Institute of Nursing was held recently at the Vassar Brothers' Hospital, Poughkeepsie, N. Y., under the direction of Joseph J. Weber, superintendent, for the benefit of the graduates of the school of nursing and any other nurses who might care to attend.

The institute was held at the request of many nurses who said that they had been out of school so long they were losing touch with modern methods of nursing and medicine, and felt a definite need for a review of sorts.

The hospital scheduled the institute, feeling that if twenty-five or thirty nurses attended it would be successful. Instead, eighty nurses registered at the meeting, and the staff felt their response would justify the presentation of a similar program next year.

Included in the day's program were lectures on the modern method of diagnosis and treatment of cholelithiasis, the liver treatment in pernicious anemia, modern methods of artificial respiration, the education of the diabetic patient, anesthetics and their application to different types of cases, nursing procedures in obstetrics and the injection treatment of varicose veins. Demonstrations of the Levine tube and other appliances were given, and a tour of the hospital included many special demonstrations in the operating room and the pediatric department.

Work of Safety Patrols Promoted by Hospital

An unusual method of participating in community welfare activities has been found by the Deaconess Hospital, Evansville, Ind. Like most other cities, Evansville has a group of school children organized as boy safety patrols. They assist other children across intersections before and after school and in other ways attempt to reduce the number of automobile casualties.

To encourage the work of the safety patrols Deaconess Hospital has offered its facilities as a meeting place. At a recent meeting at the hospital two boy patients who had been injured in accidents warned the other boys to profit by their mistakes. Talks were also given at this meeting by two traffic officers who had been victims of recent motor accidents, by the secretary of the Evansville Auto Club and by Albert G. Hahn, business manager of the hospital. The boys, who numbered about 250, were taken on a tour of the hospital at the time of this visit and were shown x-ray pictures of accident victims.

In commenting on the cooperation of the hospital in the safety patrol work, Mr. Hahn pointed out that it was building good will for the hospital in a group that in a few years would be taking a prominent part in the community life. "We are sure the boys were interested and impressed with the hospital," Mr. Hahn declares, "because they were so extremely well behaved and attentive to all that was shown them. One might think that so many boys would disrupt hospital routine. On the contrary they were orderly and thoughtful."

A Memorial That Lives

One morning in May, 1934, the superintendent of nurses of a New Jersey hospital was making rounds. In one of the rooms she came upon an old man, nearing the end of his days, moaning incessantly for "Mary." As she stood by his bed and took his hand in hers, the moaning stopped and a gentle peace came over his face. To him she was "Mary." Reluctantly the superintendent of nurses took herself away after remaining with him as long as she could.

On her return to her office she found awaiting her an honored and valued member of the hospital's board of trustees. His wife who had died a short time earlier had long been identified with the hospital, as well as with many other human services. To him the superintendent of nurses told the story of the old man. "I wish," she said, "we had a nurse for just such cases! Someone to help the patients who do not have special nurses in their hours of need. Someone to give not only nursing care but to help the forlorn and the critically ill over the rough places."

The trustee listened attentively and then spoke quietly. "I will be glad to support such a nurse on a salary basis in memory of my wife." Since then the J. G. Memorial Nurse has been a busy woman. A fourteen-year-old girl had been assaulted. She was brought in suffering the great mental and emotional shock that follows this appalling experience. The nurse stayed by, helping her to recover from

Group of school children at Evansville, Ind., who are organized as boy safety patrols.

her mental and emotional as well as her physical hurts. The young mother of an eight-month-old baby had pneumonia. The distracted husband could not afford special nurses. The Memorial Nurse took care of the patient for the four days before she died. She helped the husband in making his arrangements. Later he went to the office of the superintendent of nurses endeavoring to voice his thanks. "I didn't know this world held such great kindness," he said.

This nurse is never idle. There is always someone who is forlorn or critically ill who needs a special friend, one with skilled hands and an understanding heart. The J. G. Memorial Nurse is this friend.

To Encourage Esprit de Corps: A Circular Letter

Reprinted below is a copy of a hospital notice circulated to all employees of the Grady Hospital, Atlanta, Ga., by J. B. Franklin, superintendent.

To: Department Heads, Grady Hospital, Atlanta.

SUBJECT: Satisfied Employees

Unrest and uneasiness on the part of employees are often due to an uncertainty and a feeling of insecurity, and these prevent a person from doing his or her best work. Fear makes for cowardice, uneasiness and dissatisfaction; confidence contributes to strength, to pride, to an interest in one's work, to loyalty and therefore to success.

A constant nagging, driving, threatening attitude produces fear; a wholesome, kindly, helpful, encouraging and complimentary attitude drives away fear, makes one feel secure, engenders a wholesome interest, and brings out the best there is in an individual.

A rapid turnover in personnel is upsetting to service, reduces efficiency, and adds to the operating cost. Restlessness and fear bring about changes. Let us try to build a strong Grady organization, composed of efficient, satisfied and happy people. To this end, let us be honest, sincere, kind, cooperative and in every way helpful to those working under us, and to other members of the hospital organization in other departments.

As a fact, we compose one big hospital family. Our family chain is no stronger than its weakest link. Each of us has a definite task, and each task requires the cooperation of other departments. The impotency of any one department reduces the efficiency of all.

As a department head, are you doing your best to make those under you happier, stronger and better? Do your employees fear and dislike you, or do they respect and love you? Are they loyal and contented? Think about this question, and then think about it some more. Is there room for improvement in your own attitude? In the language of our President, we want to display the attitude of a "good neighbor."

Kiwanians Enjoy Entertainment at Hospital

Another means of interesting your community in the hospital serving it is that introduced by the Elmhurst Community Hospital, Elmhurst, Ill., when it began inviting the various service clubs in the town to hold their luncheons and dinners at the hospital, and found that much favorable comment regarding the institution was the result.

Recently the Kiwanis Club and the wives of its members held a dinner in the hospital dining room. Over sixty prominent members of the community were present, and the short talks given by the hospital personnel, the chairman of the board of trustees and the women's guild chairman were interesting and instructive. Some statistics on aspects of the hospital's work were quoted to give emphasis to the remarks.

A tour of the hospital followed the dinner, with explanations by department heads regarding the functions and facilities of their particular departments. These dinners and luncheons are always so arranged by Dr. M. F. Heidgen, superintendent, that the guests become acquainted with the personnel and uses of the hospital.

Mechanical Pencils Save Money

Recently a large hospital which nevertheless watches its expenditures very carefully began an experiment in the use of mechanical pencils in the out-patient department and on one hospital floor. This experiment was run not because the total amount spent for pencils is a large annual charge but rather because the percentage saving looked interesting.

The hospital started with eighty-three pencils all marked with the hospital name and each bearing a number from 1 to 83. As the pencils were issued the number of the pencil given to each clerk was recorded.

During the month of February the cost of leads and erasers for the eighty-three pencils was fifty-five cents. This compares with the average monthly cost of $2.14 for the same eighty-three clerks while using cedar pencils. The first cost of the mechanical pencils lettered and numbered was 8 cents each or a total of $6.64. Assuming that the average life of each pencil is one year the comparison would be as follows: first cost of mechanical pencils, $6.64; cost of lead and erasers for year, $6.60; total annual cost, $13.24; cost of cedar pencils, 12 months at $2.14 per month, $25.68—a net saving of nearly one-half.

There is of course another minor economy in mechanical pencils—the saving in cost of pencil sharpeners and the time spent in sharpening the wooden pencils.

Since some mechanical pencils have been in constant use for five years, certainly the average life of the mechanical pencil should be not less than one year, thus still further increasing the percentage saving.

Linen Guild Gives Valuable Help to Hospital

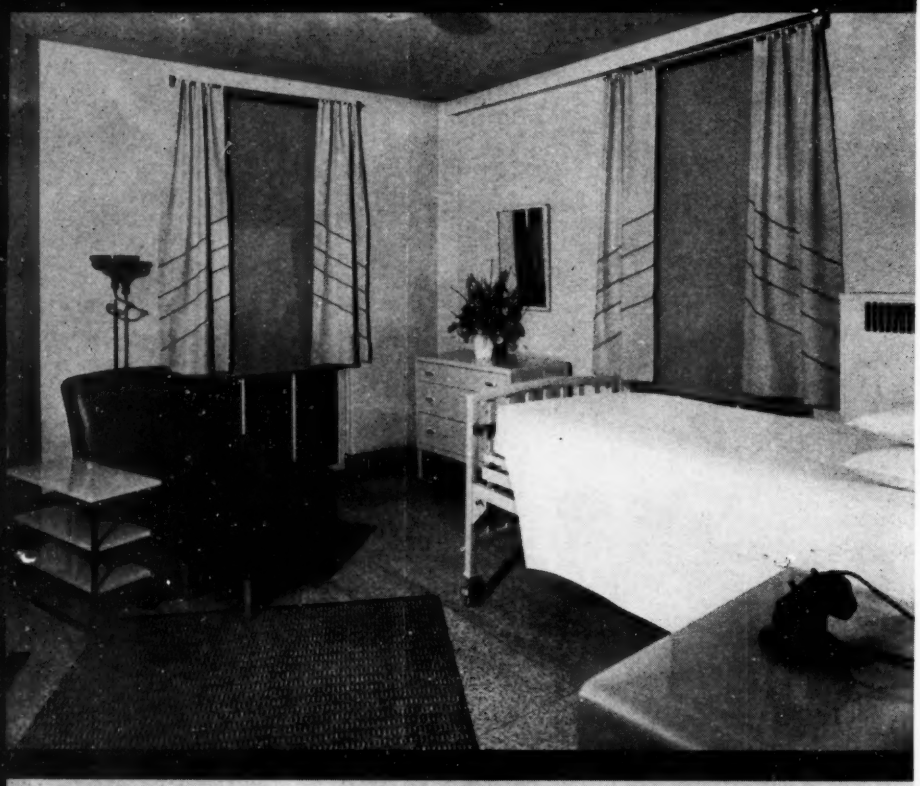
A group of women have been enlisted in the linen guild of Columbia Hospital, Milwaukee, who agree to give $10 apiece each year to help furnish the hospital's linens. This is the tenth year of the linen guild's existence according to Earl R. Chandler, superintendent.

In 1934 the guild presented the hospital with $675. The presentation was made by Mrs. J. W. Mariner, whose husband was one of the founders of the institution in 1908. The hospital also recently received $10,000 from Mr. Mariner's estate.

Another recent gift to the hospital is money for the complete modernization of one of the operating rooms in its old building. Dr. S. J. Seeger, chief of staff, has agreed to meet the cost of enlarging the room and furnishing it with new equipment. The cost will probably exceed $2,500.

Probably you can think of one or more practical ways to save time or increase efficiency. The Modern Hospital will welcome your ideas to put before other hospitals

In the reception room provided for private patients blue and gray tones are effectively combined. Gray marble covers two-thirds of the walls and meets the beautiful medium blue used on the upper part of the walls and on the ceiling. A linen rug in a blue and gray plaid design carries out the color harmony, as do the deep blue leather chairs and benches. This upholstered furniture was specially designed to scale for the hospital by the decorator.



The private room shown here has pale dusty rose furniture, harmonizing walls and an easy chair and ottoman upholstered in cinnamon brown leather. Window draperies are uniform throughout the building. They are of natural colored crash, the appropriate color accent being given by tailored bands. Windows in patients' rooms are equipped with a patented sash which pulls protective screens into place whenever a window is opened. In the main lobby (left) the walls are begonia pink, a pleasing contrast to the royal blue leather upholstery. The specially designed table tops are of acidproof, fabricated cork, in light maple tones.

Henrotin Blends Beauty and Service

By VERONICA MILLER
Superintendent, Henrotin Hospital, Chicago

ON FEBRUARY 18, Henrotin Hospital activities which since 1907 have centered in an old style six-story building at LaSalle and Oak Streets, Chicago, were transferred into a modern five-story structure. The old building is to be razed as soon as possible, and the frontage landscaped. Architects for the new building were Holabird and Root. The consulting architects, Berlin and Swern, made the preliminary layouts

Hospital equipment, practically new throughout, has been accurately correlated to fit into precise investigative routines and new alignments of departments have been developed to expand diagnostic services. Ambulatory groups and private patients of physicians on the staff may now command the same research facilities which hitherto were available to resident patients only.

The bed capacity of the institution has been increased from 75 to 104, exclusive of 20 bassinets. The maternity department has been separately organized and placed in a wing physically detached from other patients. Special services in surgery, cardiac work, metabolic study and electro-therapeutics are better manned and more closely articulated for collaboration on the part of the medical and surgical staff than has been possible before.

Modern Henrotin retains intact its traditional responsiveness to advances in medical thought and practice. It is interesting to trace the close parallel that has always been present between the successive internal changes in administration and the progressive developments in scientific medicine. Between the years of 1890 and 1918, the post-graduate medical school was the most prominent activity under our earlier incorporation as the Chicago Policlinic Hospital.

When graduate study gravitated toward universities, Henrotin Hospital logically turned toward developing improved bed services and diagnostic aids. What has happened to Henrotin and what is happening to hospitals of this size all over the country offsets the tendency of science to over-specialize in strict research divisions. Medicine here functions effectually through collaboration in the full interest of the patient.

The cubage of Henrotin's new building is no more than it was in the old, but functional plans work out a much more efficient utilization of space.

Central administration promotes compactness, clears traffic channels, directs easy communication and eliminates waste. Instead of closets, steel wardrobes have been built in. The space so saved reduces materially the cubic foot cost of the building. Specially designed cabinets are mechanical organizers of internal work. The present structure represents a 25 per cent saving in costs per bed over bids received on an earlier plan some years ago, while the staff is able to handle the work more easily than it did in the old hospital.

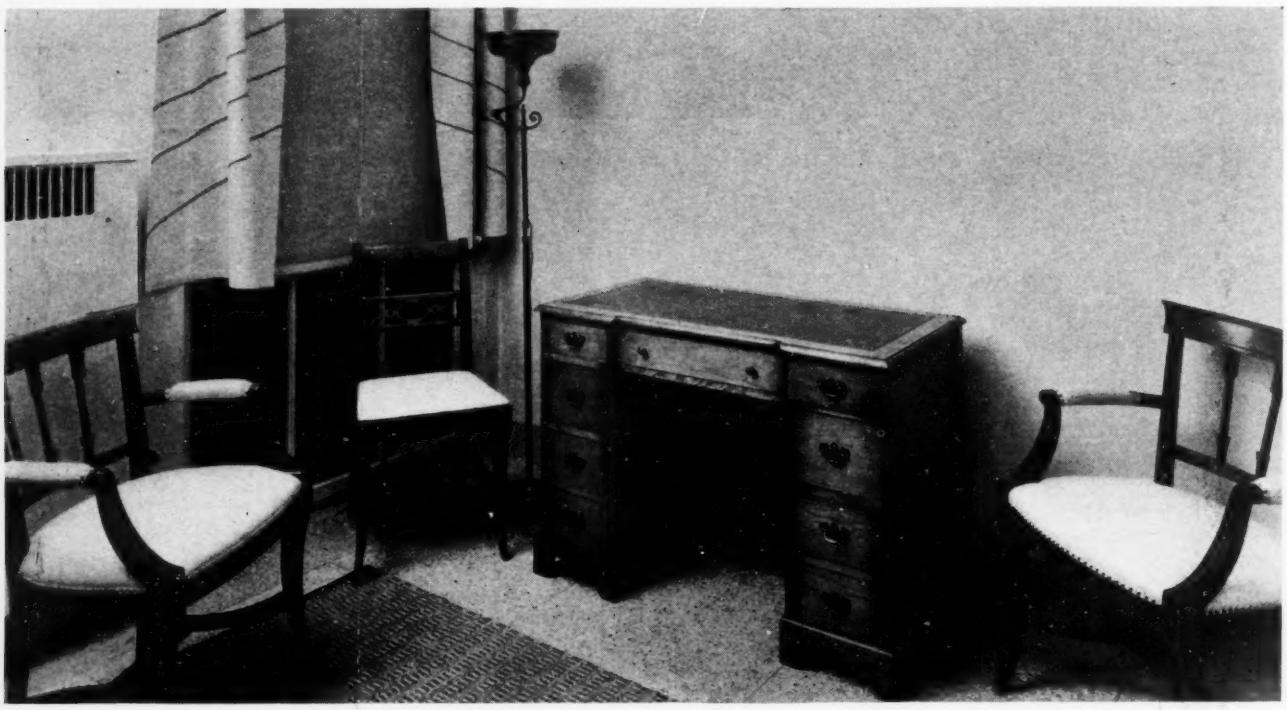
Building economies of this type represent a favorable trend among hospital groups to weigh expenditures more carefully and to demand efficiency. This is important now that general hospitals everywhere are carrying excessive service responsibilities in the face of shrinking revenues. Free medical service at Henrotin last year mounted beyond $20,000, a sum which is probably unequaled by any other unendowed institution in Chicago. During the course of building construction everything that entered into overhead, budgets, physical backgrounds of service and personnel underwent a new analysis. Every problem of management reflected in the physical plant was faced squarely.

During the building period the hospital staff was reorganized. The board of trustees consists of six physicians and five laymen, and has had a lay president since 1924. Appointments to governing boards are not limited as to time of service. This promotes stability and builds up a feeling of responsibility on the part of committee heads. To the administrative committee are delegated the responsibilities of clearing all matters that relate to administrative and financial policies. A medical executive committee meets once a month and has charge of all problems relating to medical activities within the hospital. All committees are working committees, no list has been acquired for ornament.

The new Henrotin represents an investment of approximately $600,000, including furnishings and equipment. The building fund represents the proceeds of two building campaigns widely separated in point of time, together with a cash award received from the city when LaSalle Street was widened some years ago. The building as it stands today is free of debt ready to face new adjustments unhampered by financial obligations of the past.

For a 100-bed institution giving general hospital service, Henrotin is unusually self-contained. Vacuum heat, using oil for fuel, is operated with cleanliness and a maximum degree of automatic regulation in a space saving arrangement. Radiators of the panel type are recessed in many of the more important rooms. Air conditioning was given a clinical test, and single portable units were used with such approval that equipment was set and T-joints placed to supply fully conditioned air at a somewhat later date to patients' rooms on the second, third and fourth floors in one wing of the hospital.

The basement laundry is equipped with two washers, two extractors, two compressed air ironers, a large mangle, a steam press and special blanket driers. All laundry work, including uniforms, is accounted for in pounds by each department. There is a central drug dispensary and a water softening plant. The physiotherapy depart-



On each floor to the left of the elevator is a pleasant waiting room for visitors, artistically furnished.

A special feature of the surgical department is the Harris amphitheater, with its overhead observation gallery. The lights are of the flush type, with recessed fixtures, and are equipped with prismatic lenses which concentrate shadowless light on the operating field. The gallery seats sixteen persons.

ment will provide for the routine use of violet ray treatments as cold prevention among hospital employees. The interior has been made beautiful in its appointments without any flaunting elegance, and future expansion can be arranged without disrupting the fundamental scheme.

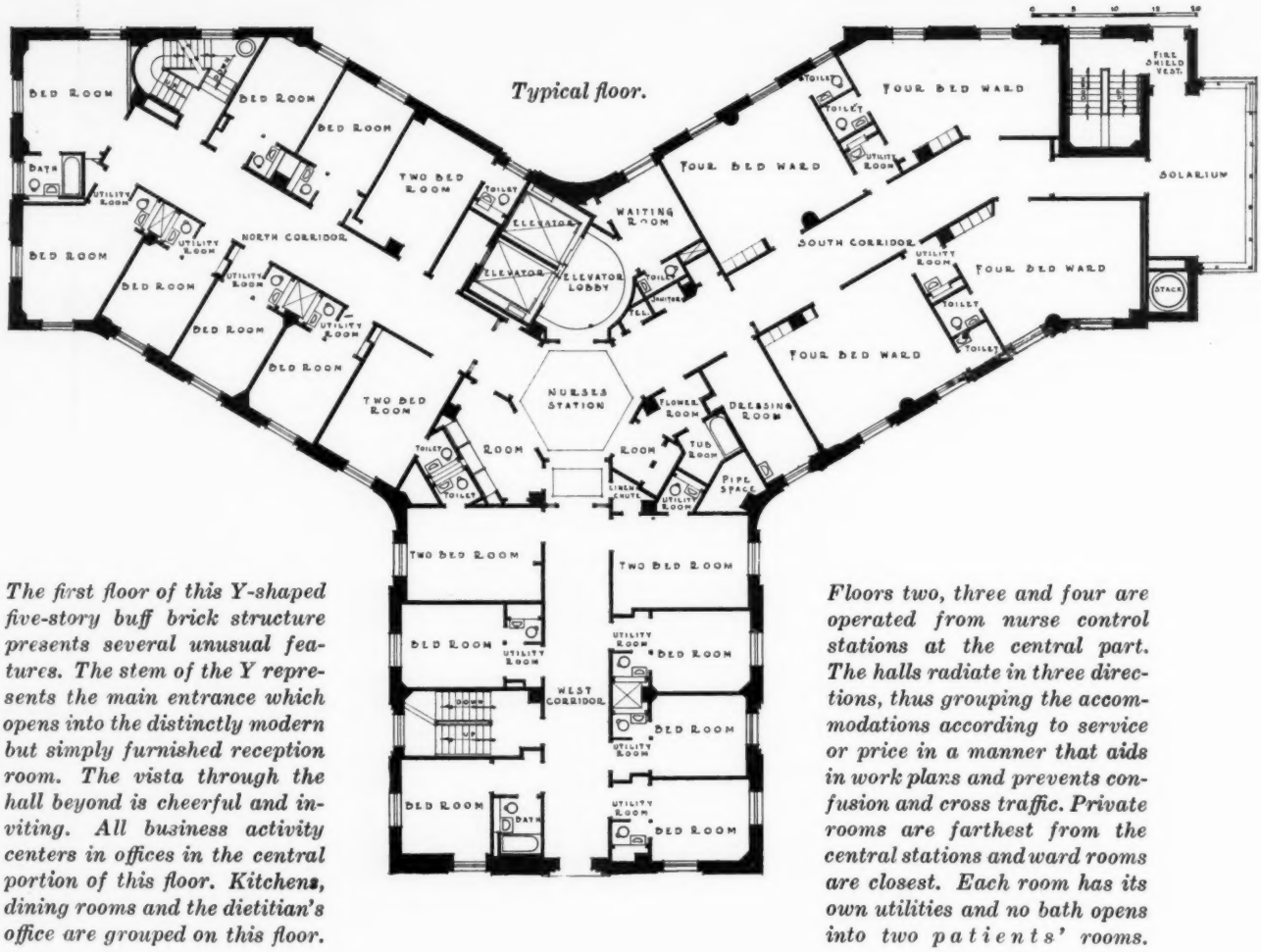
The hospital kitchens have been planned with great regard to time saving, space saving economy. Diet and general kitchens adjoin one another. All utensils are of stainless steel. The main kitchen is equipped with a milk urn, combination coffee urns, an electric toaster, a serving counter, a pot sink, a pan rack, two double deck shelf gas ranges, a gas range with a salamander broiler, one stove and roaster, one baking and roasting oven, a steam kettle, a cereal cooker, a potato peeler, a mixer with accompanying fittings and a vegetable sink. The diet kitchen has its own range with salamander broiler, a special steamer and a tray rack, allowing it to take care of its own return trays. The dishwashing room has racks all around for systematic handling of properties. The soiled dish counter connects by chute to a refrigerated garbage collector in the basement where garbage is frozen before being taken to the incinerator.

Central refrigeration of the carbonic safety type has ten tons melting capacity per sixteen hours' operation. The eleven cold storage cabinets provide a flexible use of refrigerated space with automatic regulation. The separate refrigerators include a freezing box within the meat storage room, a daily supplies storage, a vegetable and fruit space, a salad counter, a kitchen service box and a service station. Basement refrigeration takes care of the ice storage, the garbage refrigerator and the morgue. When air conditioning is installed, a separate refrigerating unit will be necessary. Circulating ice water is piped to all parts of the building. There are self-contained refrigerator units in the diet kitchen (8.2 cubic feet), the milk refrigerator (12.5 cubic feet), the laboratory unit (12.5 cubic feet), and the pharmacy (5.1 cubic feet).

The building design revolves around the plan for central administration. The arrangement of rooms is highly compact, and the direct command by central stations of every work portion of the hospital simplifies all processes of time and commodity checking.

The Y-shape of the building orients it for light, and the light values, together with the segregation of departments physically separated by branches of the Y, influenced the color plan by which the intensities, sequences and tone relationships of color treatment of walls and furniture bind together the several working units.

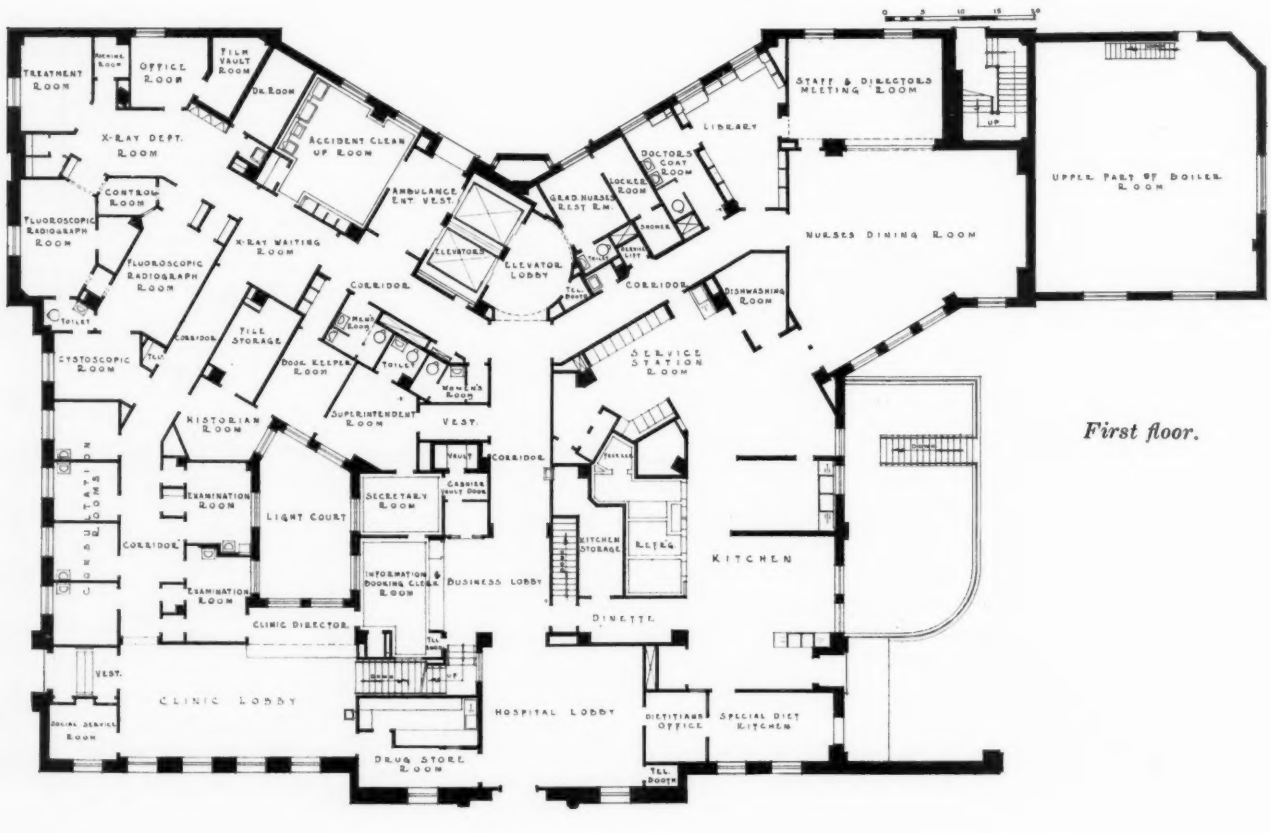
Business offices at the central portion of the building on the first floor, and nurse control stations on other floors, command the entire range of work activities through halls of minimum length. A mechanical switch intercommunicating telephone system separates incoming calls from intramural service and from calls which originate in



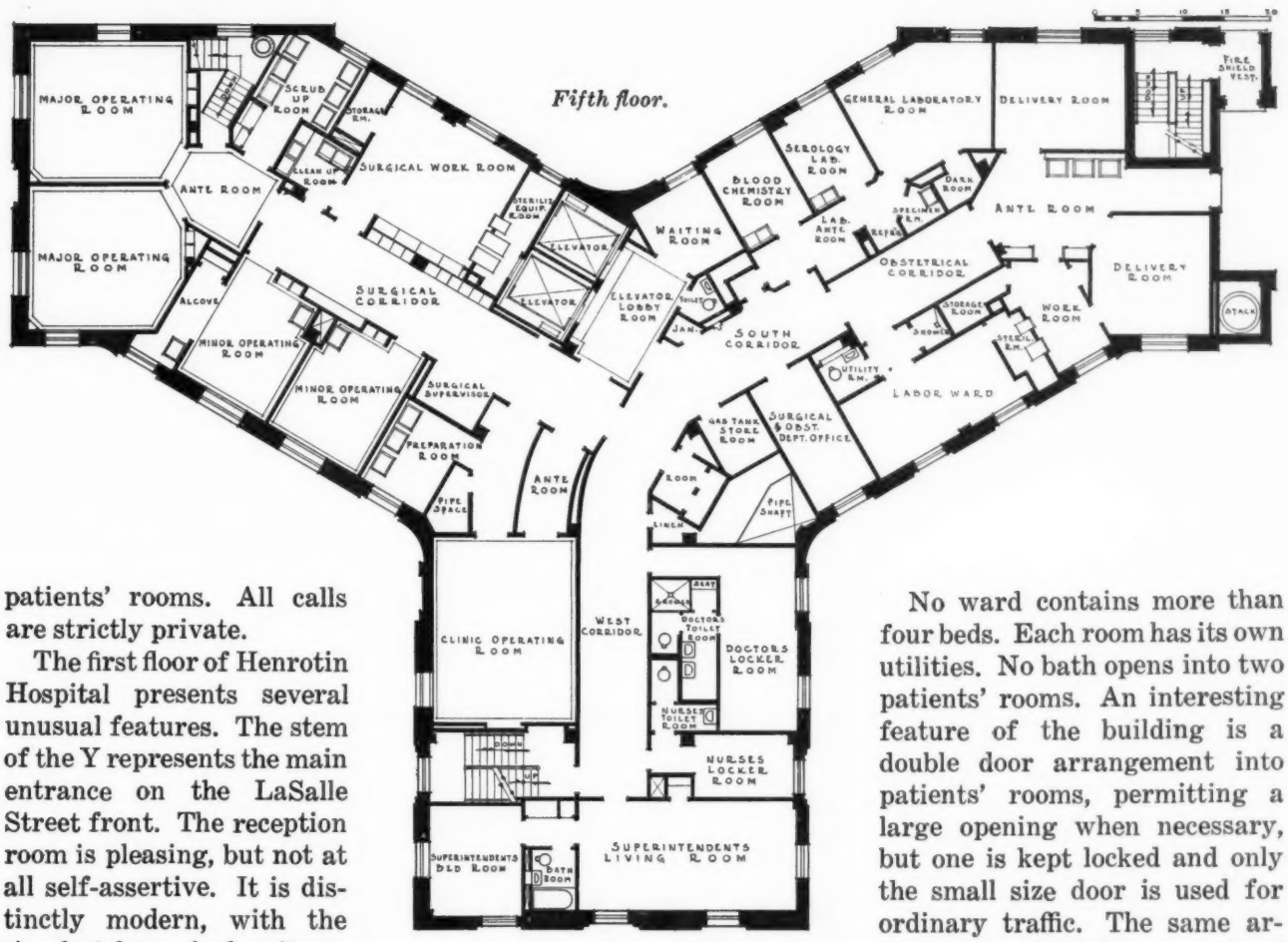
Typical floor.

The first floor of this Y-shaped five-story buff brick structure presents several unusual features. The stem of the Y represents the main entrance which opens into the distinctly modern but simply furnished reception room. The vista through the hall beyond is cheerful and inviting. All business activity centers in offices in the central portion of this floor. Kitchens, dining rooms and the dietitian's office are grouped on this floor.

Floors two, three and four are operated from nurse control stations at the central part. The halls radiate in three directions, thus grouping the accommodations according to service or price in a manner that aids in work plans and prevents confusion and cross traffic. Private rooms are farthest from the central stations and ward rooms are closest. Each room has its own utilities and no bath opens into two patients' rooms.



First floor.



patients' rooms. All calls are strictly private.

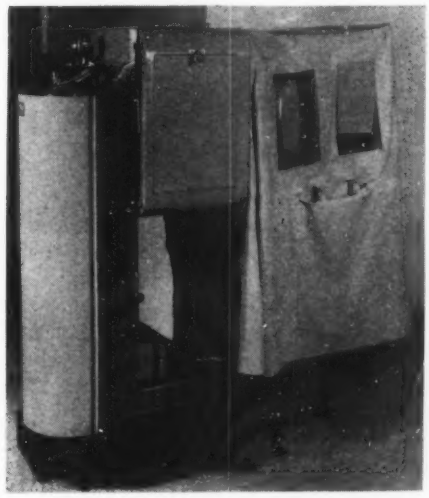
The first floor of Henrotin Hospital presents several unusual features. The stem of the Y represents the main entrance on the LaSalle Street front. The reception room is pleasing, but not at all self-assertive. It is distinctly modern, with the simplest forms in furniture. The plain walls are in pale but warm tones which answer a sort of glow in the oil-stained wooden doors and wainscot. The vista through the hall beyond is cheerful and inviting, repeating with interesting accent the high blue color of the reception room upholstery and the lambent tones in the woodwork.

All business activity centers in offices located in the central portion of the first floor of the building. The dietitian's office opens from the main reception room to the south. To the north is an entrance by way of the drug room into the Oak Street reception room provided for private patients of physicians on the staff. Their offices in this location adjoin the physical laboratories and thus bring to general practice the full facilities of hospital laboratories, x-ray equipment, complete heart and metabolic stations and physical therapy.

Kitchens and dining rooms are on the first floor, adequately segregated between the dietitian's office and the ambulance entrance. Floors two, three and four are operated from nurse control stations at the central part. The halls radiate in three directions to segregate again into service or price groupings in a manner that aids in work plans and prevents confusion and cross traffic. Private rooms are farthest from the central stations where the traffic is greatest and ward rooms are closest.

No ward contains more than four beds. Each room has its own utilities. No bath opens into two patients' rooms. An interesting feature of the building is a double door arrangement into patients' rooms, permitting a large opening when necessary, but one is kept locked and only the small size door is used for ordinary traffic. The same arrangement provides a sort of lobby into patients' rooms which deadens sound and will be useful as insulating space when air conditioning is undertaken. The large door swings back to form a private workroom in utility space.

The building is sound resistant and vibration-proof where necessary. All windows in patients' rooms are equipped with a patented sash which pulls protective screens into place whenever a window is opened. No bars are necessary for patients cannot fall from the windows of these rooms. Solariums are provided and there is ample roof space.



This modern oxygen tent is on hand for use in oxygen treatments.

One operating room has been named in honor of Dr. M. L. Harris, surgical head of the institution for thirty years. This suite has an operating theater equipped with an overhead observation gallery. The operating surgeon talks through a microphone for the benefit of visiting surgeons. Operating rooms are lighted with flush type, recessed fixtures, equipped with prismatic lenses to control and concentrate light without shadows on the operating field. Each operating unit is complete with special utilities. One sterilizer serves all surgeries, one is exclusively for obstetric service, and there is a central sterilizer in the basement.

The consultant on interior decoration, Florence L. Martin, has carried through a color plan which is consistent throughout, from the color tones of curtains and walls and the pointing of bricks, to the mixing of pigments for wood stain and paints for metal trim. Even the built-in cabinets depart from factory formulas and become important in the color scheme. The entire interior is modern, but not flagrantly so.

Color reaction is therapeutic as well as esthetic. Any beneficial effect of color must register at once on hospital patients whose stay is usually short. Therefore plain tones have been utilized to avoid ambiguity, and large unbroken color masses employed to achieve unity. When variety is desired, we have not been afraid to use emphatic accent. Curtains are plain throughout, with tailored braids which are specially designed and tested as sunproof and waterproof. All dyes and pigments used were first tested for sun and artificial light effects, for durability and for juxtapositions.

Consultant service is needed on decorative matters within the hospital, and this technical advice is just as necessary in the choice of color plans for ceilings of the laundry as it is for effects worked out for mere display. This service has money value.

Furniture Designed to Scale

There is little opportunity for artistic expression in hospital furnishings, but the unity of plan and the eminent suitability of furnishings used, achieve a definite beauty. Furniture to scale is possible and necessary in modern buildings of this type where ceiling heights do violence to the proportion of stock sizes in old types of hospital furniture.

In choosing furniture for the patients' rooms, a matched chair and ottoman were selected. In some rooms the built-in cabinets make a dresser unnecessary and enable a better chair to be provided. The easy chair is, next to the bed, the most important piece of furniture for the patient's comfort. All beds permit easy and quick adjustment to required surgical positions. The equipment is standardized, but it is not standardized to ugliness.

Fundamental economy in hospital building is not a simple thing to achieve. A balance has to be effected between things desirable from the viewpoint of the staff and the patrons and the hundreds of new developments ably presented with unremitting pressure by the trades. One strives to build efficiently and never can be certain that the net result of beauty will evolve under general service conditions. When the project is complete, there is a feeling more of relief than of exhilaration. It seems enough for the moment at least if a balanced and organized background for work has resulted from the anxious months of speculative planning.

Space Has Been Well Utilized

Dr. C. W. Munger, director, Grasslands Hospital, Valhalla, N. Y., who was chairman of the American Hospital Association's committee on building in 1934, contributes the following comments on the design and arrangement of the hospital based on his study of the text of this article and its accompanying illustrations.

"The description and plans of the new Henrotin Hospital are interesting. It seems to be essentially a Bacon Plan hospital with unusual adaptation of the plans to the site. Interior arrangement generally is excellent. The Y-shaped building is admirable from the point of view of supervision. The irregular shapes of many of the rooms are to be debited to the Y-shaped plan, however. Available space has undoubtedly been well utilized.

"The hospital lobby, from the photograph, seems very attractive. The information desk does not open directly upon this lobby and apparently leaves it without any particular supervision. This is to be regretted. The superintendent's office and several other rooms open on a small light-court on the first floor and have no real outside exposure. This undesirable feature may be less serious in fact than it appears in the plans.

"Arrangement of operating and delivery rooms is very good. One would question whether five operating rooms and two delivery rooms are necessary for a 104-bed hospital. Quite possibly these suites were designed with an eye to future additions to bed capacity. The location of the laboratory, although entirely separate from the delivery room corridor, is close to it. Such would probably not meet the wishes of those who advocate complete segregation of obstetrics from other hospital activities nor is it consistent with the careful segregation elsewhere in the building of obstetrical from other patients. I believe it a satisfactory arrangement, however.

"From the description and the plans it is evident that this building is utilitarian, attractive and a noteworthy addition to Chicago hospitals"

Distinguished Service— By Community Relations

These changing times demand a new social and economical viewpoint from the hospital. It can no longer remain isolated in the heart of a community, centering itself within its walls. Co-operation with other social agencies has become vital, says this second article on distinguished service

UNDER the economic pressure of these times two almost completely opposed views predominate in the hospital field—the one, isolation, the other, that of aligning the hospital with community activities having similar aims.

The isolation policy promotes intensified study, administration and work within the specialized field of hospital functions alone. It assumes that if the hospital does its specific job well—and all other institutions do their jobs well—the greatest progress automatically obtains. Within limits this is sound.

Eventually, however, it leads to an attitude of indifference regarding the cooperation of one hospital with another and the cooperation of hospitals generally with other public health agencies and social service, until finally it actually causes some managements to shy at and refuse even the most fundamental cooperative efforts. This policy has an organic weakness. It pretends that one institution, the hospital, may, without regard for the overlapping functions of other social agencies, define its own function clearly.

Hospitals Should Be Good "Mixers"

The stress of these times makes it imperative that hospitals should cease to be walled towns. They must intimately utilize other local agencies.[1] Too many times have hospitals been lone workers when better results might have been obtained through cooperation with other social agencies interested in community programs. Hospitals should be represented whenever possible in community health programs and every opportunity should be used to work with medical associations, county organizations and private agencies in improving social conditions.[2] The cloistered position is ineffective.

The second policy, then, is that of broadly relating the hospital to all social activities in the community which overlap its functions. Most hospital leaders favor this course.

The thought expressed most frequently is that fast changing social conditions must be faced and met by corresponding changes in hospitals.[3, 4] More far-sighted planning will have to be done than has been done in the past.[5] The hospital should encourage close and cordial relations with health and medical associations and should promote effective public relationships.[6, 7] Hospital services must be integrated with related social services[8] if the hospital is to take an important part in the establishment of social security for all.[3] It is especially pointed out that hospitals in large cities should take an interest in all community affairs connected, directly or indirectly, with public health and medicine[9] and this ought to be equally important in rural hospitals. It is generally agreed that independent hospitals will make their way from now on in proportion to their capacity for analyzing the needs of their community and devising methods of meeting them.[10, 11] One observer suggests that right now further standardization should be standardization for community service.[12]

Specifically, there is a widespread demand that hospitals, through their out-patient departments, enter into active cooperation with each other and with all accepted public health agencies in their community.[13, 14] Direct leadership assumed by hospitals can often change a hit or miss community health program into a well directed positive plan.[15] It is suggested that hospitals unite in a community health council and study the needs of the area and the existing facilities to meet them.[14]

Working arrangements between hospitals and boards of health are deemed advisable, and in one instance the suggestion is made that hospital superintendents should be members of the board of health.[16] Concrete service which could be rendered to the health departments by hospitals is the pro-

vision of adequate laboratory service at cost,[17] for in smaller cities adequate laboratory facilities are frequently not maintained by health departments. Some go so far as to suggest that in smaller cities and towns, hospitals should house all accredited agencies having to do with the health of the community,[18,19] including the visiting nurses' association. In large cities this organization might establish local units in various hospitals.[20,21] All these would be coordinated through the out-patient departments.

In smaller communities, and indeed even in large cities, the hospital out-patient department, the public health department and the visiting nurses' association should have a cross reference system in operation among them. Then when an out-patient department discharged a case it would be picked up by the visiting nurse service or public health department. In any event discharged cases should be referred to the proper social agencies after the hospital's direct interest has ceased, so that a suitable agency may take up the work where the hospital leaves off. Some suggest that the hospital should employ a thoroughly trained social worker to be assigned to work in the central or district offices of the council or union of social agencies to interpret the work of the hospital and act as liaison officer between the hospital and other social agencies. In some instances it is being demonstrated that this method of working together benefits all the organizations concerned and that in these cases the public shows great interest in a unified health program.[22,23,24,25]

Parallel with these ideas is a distinct need for clearer and closer definitions of the relationship of private and public philanthropy and the fields of operation for the voluntary hospital and the government hospital.[3]

One Reason for Vacant Beds

There has been a tendency for all hospitals to become general hospitals. Many which started out in specialized fields, such as maternity or children's service, have increased their scope so that annually we have more general and fewer specialized institutions. There has been a tendency for general hospitals to become active in specialized services and these trends have been responsible for many unoccupied beds. This means increased costs.

In this particular problem and in many others there is great need for hospitals to work together. After all, hospitals in a community are engaged in a common enterprise and the interests of the public are paramount. Among hospitals in one area there should exist a cooperative rather than a competitive attitude, and anything which can bring about cooperation in behalf of the public is of greatest value not only to the whole community but to the individual hospital.[27,28,29,30]

It cannot be assumed that hospitals will always see this need even when it exists plainly. Often it is difficult to get hospital boards to accept suggestions of a constructive nature if the ideas are promulgated by other hospital people and in such a situation, it might be that suggestions from an interested public would stir up more action.

Hospital boards, and particularly hospital staffs, are loath to lose their individuality which they feel may be jeopardized by cooperative moves. In many places the problem is such that narrow sentiment should no longer act as an obstruction to community welfare. If this is not realized, the public should take action. Frequently an independent survey making impartial recommendations with regard to the exact status of voluntary hospitals and the way they serve the community would bring about some interesting and productive results. Hospital boards could not ignore this public opinion.[12]

Hospital Councils Widely Endorsed

As these suggestions for better hospital service were being assembled it became obvious that most respondents believe the hospital council is the most effective mechanism for hospital cooperation. Some believe that every city of any size should organize a council and that it should not come into being with the idea that it is to serve the member hospitals alone but that its first objective should be improved service to the community.[7,26,28,31]

Developments along this line during the past few years have been truly encouraging. They come at a most appropriate time, for if hospitals are to adjust themselves to changes there will be need for more and more cooperative effort.[26] The Cleveland council is the one to which reference is repeatedly made.

Two other matters of general policy in hospitals come up at this time. The first of these suggestions is that voluntary hospitals should set about by every means at their disposal to establish a better basis of support for charitable work. In the past voluntary hospitals have received funds for this work spasmodically. It is generally recognized that they must extend charitable work, yet no continually reliable method of financing it has been evolved.[32] This is a crucial problem today.

The other suggestion is that boards of trustees should make a canvass of all possibilities of refinancing any capital debts now burdening their hospitals. At present many such debts might be refinanced at considerably lower rates and prolonged periods of amortization. This in turn would reduce overhead operating costs.[15]

While in the main all constructive moves in the

hospital field are made to improve service, the problem we face today is that of reducing costs and making them more equitable. The majority of low and middle income citizens cannot under present circumstances and arrangements pay for the hospital service they need and do not get. Costs must be reduced and made easier to pay.[5, 33, 34] Until hospitals can effect necessary economies, further public confidence cannot be expected.[36]

Many different methods of reducing costs or making them easier to pay are being attempted. The San Diego Medical Society sponsors the Central Clinic Service which maintains a sliding scale of charges for health services.

Many hospitals are trying the flat rate method of charge, particularly for maternity service. Four such hospitals came directly within observation in this survey. Some hospitals are experimenting with flat rate charges for all services, and in most instances the result is increased patronage.[38, 39, 40] The charges vary greatly in amount. Sometimes a fee for the family physician or obstetrician is included in the charge. In several instances hospitals have lost money when flat rate services were kept up to standard. Some believe that while we should experiment as widely as possible with flat rate charges, we are liable to find them to be not much more than arbitrary accounting.[38]

Others believe that the establishment of hospital controlled funds (not for profit) from which needy persons may borrow at low rates of interest to finance hospital service are a long step in the right direction.[18] The work of the Cleveland Hospital Finance Corporation is again cited.[41]

Group Hospitalization Coming Into Its Own

But by far the greatest number of those who discuss hospital service costs recommend group hospitalization as the solution of the problem.[3, 5, 7, 13, 26, 32, 42, 43, 44, 45] This method spreads hospital costs not only over a period of time but over a large number of income producing individuals and families. Although the idea of group hospitalization had at first to overcome a great deal of latent resistance and inertia, it is widely accepted now as the one best method of placing hospital service costs within reach of the great majority. Putting the idea into operation has also been a difficult task in many places, but it is becoming easier with experience.[44]

One difficulty encountered has been that in the face of unknown costs the figures for the service have been too high.[13]

Another and perhaps the greatest difficulty in putting the group hospitalization plan into effect has been that properly organized and directed sales and promotion programs have seldom been undertaken.[13] Hospital personnel are rarely qualified and able to undertake effective campaigns for sales and promotion of this or similar ideas. There are available, however, firms and individuals who are well qualified in general research, planning, and promotional work for hospitals. These may be employed on a straight salary or retainer basis, thus eliminating any accusation that the plans are organized for private profit.

In the long run group hospitalization may be expected to accomplish three things: (1) bring hospital care within the reach of the citizen who desires to be self-supporting and refuses charity; (2) increase the use of hospital facilities, and (3) stabilize the income of hospitals.[44]

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[1]George H. Bigelow, M.D., former director, Massachusetts General Hospital, Boston.
[2]Grace Crafts, superintendent, Madison General Hospital, Madison, Wis.
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[4]Robert E. Neff, administrator, University of Iowa Hospitals, Iowa City, Iowa.
[5]R. W. Nelson, manager, Portland Sanitarium and Hospital, Portland, Ore.
[6]Oliver H. Bartine, superintendent, Bridgeport Hospital, Bridgeport, Conn.
[7]R. H. Bishop, Jr., M.D., director, University Hospitals, Cleveland.
[8]A. C. Bachmeyer, M.D., director, University Clinics, University of Chicago.
[9]William A. White, M.D., superintendent, St. Elizabeth's Hospital, Washington, D. C.
[10]Ray Lyman Wilbur, M.D., president, Stanford University.
[11]S. S. Goldwater, M.D., commissioner of hospitals, New York City.
[12]Donald C. Smelzer, M.D., director, Graduate Hospital of the University of Pennsylvania, Philadelphia.
[13]C.-E. A. Winslow, Dr. P.H., school of medicine, Yale University.
[14]Malcolm T. MacEachern, M.D., director of hospital activities, American College of Surgeons, Chicago.
[15]B. W. Black, M.D., medical director, Alameda County Institutions, Oakland, Calif.
[16]Leonard A. Lubbock, superintendent, Princeton Hospital, Princeton, N. J.
[17]Ada Belle McCleery, R.N., superintendent, Evanston Hospital, Evanston, Ill.
[18]William E. Proffitt, superintendent, Tompkins County Memorial Hospital, Ithaca, N. Y.
[19]W. S. Rankin, M.D., director, hospital and orphans section, The Duke Endowment, Charlotte, N. C.
[20]Michael M. Davis, Ph.D., director for medical services, Julius Rosenwald Fund, Chicago.
[21]C. W. Munger, M.D., superintendent, Grasslands Hospital, Valhalla, N. Y.
[22]H. J. Southmayd, director, division of rural hospitals, Commonwealth Fund, New York City.
[23]Walter P. Bowers, M.D., managing editor, New England Journal of Medicine, Boston.
[24]Charles H. Dabbs, superintendent, Tuomey Hospital, Sumter, S. C.
[25]Mrs. Byrd B. Holmes, superintendent, Greenville City Hospital, Greenville, S. C.
[26]John R. Mannix, assistant director, University Hospitals of Cleveland.
[27]George Crile, M.D., Cleveland.
[28]Carolyn E. Davis, superintendent, Good Samaritan Hospital, Portland, Ore.
[29]Earl B. McKinley, dean, school of medicine, George Washington University, Washington, D. C.
[30]Capt. Harry H. Warfield, superintendent, St. John's Riverside Hospital, Yonkers, N. Y.
[31]Asa S. Bacon, superintendent, Presbyterian Hospital, Chicago.
[32]Winford H. Smith, M.D., director, Johns Hopkins Hospital, Baltimore.
[33]W. G. Christie, superintendent, Presbyterian Hospital, Denver.
[34]Lee C. Gammill, superintendent, Baptist State Hospital, Little Rock, Ark.
[35]F. G. Carter, M.D., superintendent, Ancker Hospital, St. Paul.
[36]John C. Mackenzie, M.D., superintendent, Montreal General Hospital, Montreal, Que.
[37]C. E. Sisson, M.D., superintendent, San Diego County General Hospital, San Diego, Calif.
[38]Irving S. Cutter, M.D., dean, Northwestern University Medical School; director, Passavant Hospital, Chicago.
[39]William B. Sweeney, superintendent, Windham County Memorial Hospital, Willimantic, Conn.
[40]Joseph J. Weber, superintendent, Vassar Brothers Hospital, Poughkeepsie, N. Y.
[41]C. S. Woods, M.D., superintendent, St. Lukes Hospital, Cleveland.
[42]A. M. Calvin, executive manager, Midway and Mounds Park Hospitals, St. Paul.
[43]Emil G. Chinlund, M.D., director, Immanuel Deaconess Institute, Omaha, Neb.
[44]Esther Squire, R.N., superintendent, Community Hospital, Grinnell, Iowa.
[45]M. C. Winternitz, M.D., dean, school of medicine, Yale University.

NATIONAL HOSPITAL DAY

May 12

At the top of the page is shown a group of mothers and babies who attended an anniversary party at Copley Hospital, Aurora, Ill., on National Hospital Day. . . . Nurses' uniforms of the 1900 period are shown above and on the left are two junior alumni of the Lutheran Hospital, Brooklyn, New York.

The annual Florence Nightingale Service is held every year at the Cathedral of St. John the Divine, New York, on the Sunday that falls nearest to May 12, Florence Nightingale's birthday. Red Cross nurses, public health nurses and nurses representing nursing schools from all over the country attend, wearing their distinguishing uniforms and caps. Large groups of student nurses are also present. In the lower picture is seen against the black drop one of the tableaux presented at St. Vincent's Hospital, New York City, last year on National Hospital Day. It shows a hospital room of a century ago contrasted with a hospital room of today.

Wide World Photo

Someone Has Asked—

Should the Hospital Engage Summer Interns?

Some institutions make a practice of engaging senior medical students to serve on regular intern assignments during the summer months. Such an arrangement makes possible the carrying on of regular services without interruption during the vacations of the regular staff members. To be sure such junior interns must be carefully selected in order to prevent the acceptance of young men who might fail to observe hospital regulations or might not fit into hospital routine. From the student's standpoint a summer spent in the hospital is a profitable investment. Working under supervision these young men and women are able to gain experience not procurable in any other way.

There is still another angle to this matter. Carefully selected and supervised summer interns make excellent material for the regular intern group. This plan when properly organized thus acts as a training school for interns for the coming year. In some cases it has been thought that the acceptance of summer interns discouraged the application of others for the regular examination. This, however, need not be the case and the contract which the summer intern signs should state that he expects no preference to be shown him in the coming contest for places on the intern staff and that if he should secure such an appointment it will be as a result of winning in open competition with others.

The summer intern system is rather to be commended and is another contribution the hospital may make in preparing young doctors for future service to their communities.

When May a Ward Patient Be Transferred to a Private Room?

In asking this question the superintendent explains its origin. In his hospital, accident patients are frequently admitted to the surgical ward after having received emergency treatment in the receiving ward. In some instances extensive emergency surgical treatment has been necessary and has been promptly given by a member of the visiting staff.

Within twenty-four hours after the reception of such a patient it is not uncommon for a request to be received for the transfer of the patient to a private room under the treatment of the family physician who enjoys courtesy staff privileges. The staff surgeon objects to this procedure because not only was no charge made for the operating room and for the other services usually rendered on a fee basis to private patients but also the surgeon received no recompense for his services.

Such a practice would appear to be actually if not deliberately evasive. In some instances, no doubt, the family physician requests or is asked to assume charge of treatment. In others, the patient is deliberately admitted to a ward, receives surgical care and then is transferred to private quarters to convalesce. It is a rule in most institutions that no patient may be transferred from a ward to a private room until all the financial obligations are met that have been incurred as a result of ward care. When the reverse is true and the request is made for the transfer of a patient from a private room to a ward bed, it is customary to require that all expenses incurred in this type of care be met before the permission is given.

Is a Direct Exchange System for Supplies Profitable?

Hospitals in their search for methods of economy have properly turned their attention to checking the efficiency of the purchase, storage and issuance of supplies. Long before the present economic stringency, many institutions prepared lists of expendable and nonexpendable articles, requiring that nonexpendable articles considered useless because of breakage or wear should be returned to the storehouse before replacements were made.

A nonexpendable list, of course, includes articles of such value and usefulness that they tempt those inclined to dishonesty or create a considerable loss to the hospital when broken or mislaid through carelessness. Such a list includes all types of glassware, except perhaps such articles as catheters and feeding tubes, surgical instruments and all other equipment which is of similar type.

Enforcement of this replacement principle may be carried to an absurdity, however. When such articles as medicine droppers, feeding tubes, glass catheters, nipples, orange wood sticks and nail files are included in this list, the amount of nurses' time required to check and inventory these articles, compared with the possible saving involved, represents an actual loss instead of an economy.

How Can We Prevent Impetigo in the Maternity Wards?

The occurrence of impetigo in the hospital maternity wards is exceedingly dangerous to the newborn and extremely costly to the hospital.

This condition is usually of staphylococcic origin and is easily transmitted from one child to another. It is often due to uncleanliness and overcrowding. Poor nursery technique and a defiance of the laws of aseptic nursing are also causative. Moreover, the tender skin of the newborn, being easily macerated by perspiration and by the humidity of summer, offers a lowered resistance to the entrance of these germs.

Preventive measures seem fairly obvious. Adoption of the strictest type of aseptic nursing in handling all babies, both ward and private, is highly essential. Cleanliness of the highest grade in the maternity department is demanded. The insistence on the practice of the most careful technique by the members of the staff at delivery and during the treatment of the umbilical stump is, of course, vital. Proper summer clothing for the newborn, avoidance of irritating inunctions, oils or soaps and daily inspection of the bodies of nursery patients for early lesions are effective common sense measures. Hence, good nursing, uncompromising cleanliness and a high grade of medical service, together with the avoidance of overcrowding, are usually effective methods of prevention of the disease.

If you have any questions to ask, the editor will be glad to discuss these in a forthcoming issue

Indexing Made Easy

By T. R. PONTON, M.D.
Chicago

The primary purpose of any system of indexing and filing of medical records is to make the records easily available, to supply information about the patient and to serve for purposes of research. The index is made as a reference to the record, from which information is to be secured and cannot be used to furnish any but the simplest information without its becoming so complicated as to be useless

THERE are three systems of filing medical records, the alphabetical, the classified and the numerical. In the alphabetical, the record is filed according to the name of the patient. This system is too unwieldy for any but the smallest hospital and has been almost entirely abandoned. With the classified system the record is filed according to the main diagnosis, with cross reference for complications. This system makes the record available for research but is very complicated for any other purpose and the system is being gradually abandoned. The most generally used system is the numerical, where the record is filed under an assigned number, various indexes being used to refer to this number.

The four modifications of this last and most popular type of filing are as follows:

1. Unit system, centralized. The patient has one number for all admissions and all records are filed in a central office under that number. The system is suitable for a hospital to which patients are constantly returning and in which the departments are convenient to a central office.

2. Unit system, decentralized. The patient has one number for all admissions but records are filed separately in different departments. This system is suitable for a hospital to which patients are constantly returning but where departments are so located that central filing is inconvenient.

3. Serial system, centralized. The patient is given a new number on each admission and all records are filed in a central office. The system is suitable for an active hospital that has a records office convenient to both the in and out-patient departments, and to which patients do not frequently return.

4. Serial system, decentralized. The patient is given a new number on each admission to each department and the records are filed in the department under the department number. The system is suitable for an active hospital to which patients do not frequently return and in which departments are so located that central filing is inconvenient.

Under any system of numerical filing it is necessary to keep indexes for reference to the file number. Those commonly kept are the patient's index, the disease index and the operation index.

The most suitable patient's index is one of the standard card systems, a card being made for each patient which refers to the file number. As additional identification it is customary to add such information as the name of the attending doctor and the date of admission. These cards are filed absolutely alphabetically, down to the last letter of the name, the surname being used first. A card index may be yearly or perpetual. If yearly indexes are kept, those for each year are kept separately, if perpetual, they are kept all together. The perpetual form is recommended.

Alphabetical System Offers Simplicity

Systems of disease indexing may be divided into two types, classified and alphabetical.

Under the classified systems of disease indexing, cards are invariably used. Each card is headed by the name of the disease and the classification symbol. Two types of cards are generally used, one for the main diagnosis and one for complications. The cards are filed in accordance with the classification.

Under an alphabetical system either loose leaf pages or a card system is used. The page (or card) is headed with the name of the disease and the classification symbol as in the classified systems. The essential difference is that the cards are arranged alphabetically according to the name of the disease. Pages are made for complications as well as for the main diagnosis. The great advantage of the system is its simplicity. When an indexing

entry is to be made it is necessary only to find the page in its correct alphabetical position. Reference to the nomenclature is necessary only when a new disease is met with, one for which a page has not been previously opened. While the alphabetical nomenclature is particularly adapted to this system, any nomenclature may be used without great disadvantage or complication.

The alphabetical system is applicable to hospitals of all sizes and types, but the present article has reference particularly to the smaller hospital, in which the librarian probably has other duties to perform.

Avoiding Duplicate Registrations

The required admission data are secured and entered on the statistics or summary card, which is numbered following the system in use. If the serial system of numbering is used, cards may be numbered as far ahead as desired, if a unit system, the patient's number is secured from the index and entered at the time of admission.

In order to avoid duplication or omission of numbers it is necessary to keep a patients' register which is used for this purpose alone, and the simplest form is recommended. If a serial numbering system is used the register may be numbered ahead, if a unit system is used the number will be entered at the time of admission. The patient's chart and card are sent to the records office after discharge. Both are made complete by the combined efforts of the medical staff and the librarian, after which the record is filed in the permanent file. The card is filed alphabetically according to the name of the patient in a temporary file until all indexing is done and the monthly analysis has been made.

The disease index may be loose leaf or a card system. In the larger hospital the loose leaf system is less expensive and more convenient. In the small hospital if card files are already available the expense of purchasing loose leaf binders may be avoided.

How Many Subdivisions Are Needed?

In determining the detail of indexing, the first question to be decided is the amount of subdivision of main terms that is desirable. The guiding principle is the comparative amount of work involved in indexing and finding records when required. Extensive subdivision is not advisable when the indexing entries are few and the record can be made easily available for consultation with little or no subdivision.

Records concerning abscesses of superficial surfaces, for example, will rarely be required for study, hence it is advisable to enter all on one page headed "Abscess, Superficial Surfaces." Other abscesses may be indexed on one page "Abscess, Miscellaneous," or there may be subdivision according to region depending on the frequency with which the records are used for the study of groups of cases.

Carcinoma is another typical example. In the small hospital treating few carcinomata it will be advisable to index all on one page rather than make a separate page for each region. If the records of carcinoma of any particular region are required it will entail less effort to pick out the cases from this one page than to keep many pages with few entries on each. On the other hand, in the large hospital having a tumor clinic or in the special cancer hospital, either of them doing research work, it would be simpler to index the carcinomata of each region on a separate page than to be constantly searching through a large number of entries when any particular carcinoma is required.

Special Guide System Advisable

Under any system of indexing, setting up the index is laborious but it is advisable to do this at the start. The librarian first goes through her nomenclature and selects those diseases which her experience shows she is likely to encounter. Pages (or cards) are made for these and are arranged alphabetically in the binder (or file). When disease terms not selected at this time are encountered in subsequent indexing the librarian consults her nomenclature to be certain that the term is authorized, and if so she makes a new page and inserts it in its correct alphabetical position.

In order to separate the pages (or cards) for easy reference, guides are required. The ordinary A. B. C. guides may be used but are not satisfactory and it will be better to secure a special guide system.

The actual indexing is done from the statistics or summary cards on which the librarian has made certain that the final diagnosis is correctly entered. The main diagnosis and all complications are indexed to their proper pages, the entry in each case showing the other diagnoses of the case in the column "Complications." As each disease is entered it is initialed on the statistics or summary card.

For instance, the diagnosis is acute gangrenous appendicitis with general peritonitis. On the page headed "Appendicitis, Acute Gangrenous," the filing number is entered in the first column, "General Peritonitis" in the complications column, and other information as indicated. Since this is the main diagnosis the letter "P" is inserted after the number. On the page headed "Peritonitis, General," the entries are identical except that the

entry in the complications column is "Appendicitis, Acute Gangrenous," and since this is not the main diagnosis the letter "P" is omitted after the number in this case.

The index is thus an index of disease, not of patients, and gross totals will be greater than the number of patients discharged. The total of all entries having the letter "P" after the number will correspond to the number of patients discharged.

Compiling Reports From Indexes

At the end of the year all columns of the index pages will be totaled and a line drawn below this series of totals to close the page for the year. Indexing for the next year is then commenced on the same page. A new index is not commenced each year except in the very large hospital. The process of closing and carrying on is repeated year after year, until the index becomes too large for convenience, when it is bound (or transferred if cards are used) and a new index is set up.

The alphabetical system is the only one that has provided for a separate index of operations, so important to the surgeon who wishes to study the technique or results of any operation. The whole procedure is the same as that described under the disease index. Librarians are cautioned to exercise care that diseases are not indexed as operations and vice versa. Much confusion has resulted under the older systems from carelessness in this respect. As with the disease index special guides greatly facilitate the work.

At the end of each month it is presumed that all indexing has been completed and that the statistics or summary cards are in the temporary file to be used for making the monthly analysis or any other statistical report that the hospital may require as routine.

In making the analysis recommended by the American College of Surgeons, the analysis of gross results, recovered, improved, is done first. The cards of patients discharged are sorted according to results so far as main diagnosis is concerned, the number of cards (patients) counted and the total entered in the proper place.

Next is the service analysis. At the time the main diagnosis was indexed, the service classification was entered at the upper right-hand corner of the card. The cards are now sorted according to this classification, the number in each service is counted and entered and finally deaths, necropsies, consultations and infections in each service are counted and entered. When all have been entered percentages are worked out. In making the monthly analysis, the deaths and infections are picked out and entered in the space provided. The entry in each case is the hospital number and the diagnosis.

After all reports have been made and all indexes entered, the statistics or summary card is filed permanently. It is recommended that this card be filed separately from the medical record, and numerically. It is found that 2,000 cards can be filed in the space required for 200 records of average bulk, thus allowing summaries of a large number of cases to be kept in the office. Since the summary contains all sociologic data and much important medical data a large percentage of inquiries about the patient may be answered by reference to the card. When so large a number of cards can be kept in the office queries may be answered without delay.

Some hospitals prefer to file these cards alphabetically, using them to replace the patients' index. This is not advisable if there is free access to the file which might entail a danger of losing the index, making the record very difficult to find.

Preparing the Annual Report

In some hospitals the annual report is a brief statement of the results as shown in the monthly analysis. If this is all that is required the librarian merely combines the twelve monthly analyses and her annual report is completed. In other hospitals a complete list of diseases treated and of operations performed is required. Such lists are compiled from the indexes. Under a strict alphabetical system they will be listed alphabetically, totals being shown as found in the indexes.

If the report is required under any of the systems of classification the process is simple but entails a little more work. The pages (or cards) of the index are removed from the binder (or file) and sorted according to the classification symbol. The report is then made following the new arrangement and after it is made the pages (or cards) are restored to their alphabetical order.

How to Change Indexing System

Many cases are encountered in which the hospital, recognizing the simplicity of the alphabetical system, wishes to adopt it but does not wish to abandon old indexes or to change from a nomenclature to which the staff is accustomed. The change can be easily made without either sacrifice.

In all the old classified systems cards are used for indexing, each card having the name of the disease and the classification symbol at the top. These are arranged behind a more or less elaborate system of guides. To change to an alphabetical system it is necessary only to rearrange the cards. The old classification guides are abandoned, alphabetical guides substituted and the disease cards arranged alphabetically behind the new guides.

A Patient Tells Us Our Faults

By MARY L. BRUNDAGE
Washington, D. C.

AFTER a week's stay in one of America's leading hospitals — one noted for the beauty of its architecture and the distinguished character of its medical staff — I have come to the seasoned conclusion that every hospital superintendent and every superintendent of nurses should be compelled to spend two or three days a year as an incognito patient in his own hospital.

Perhaps I got off to a bad start. When I arrived about 6 p.m. Sunday night, my bed in a four-bed private ward having previously been reserved, I assumed they would bring some supper shortly. I was scheduled for an operation on my hand next morning, so my difficulty did not interfere with a normal healthy appetite. When no food had arrived by 7:30 I spoke to the intern. He asked the nurse and she said there wasn't any way of getting food at that time of night. At his insistence, she did manage to get me tea and two very thin, dainty slices of toast. When the intern protested about such an ethereal meal, the nurse replied, "We never have food on the floor at this time of day."

The next morning, in spite of the fact that I wasn't to have any breakfast, since my operation was scheduled for 9 a.m., I was wakened at 5 by a nurse who said with cruel cheerfulness, "Well, have you had a nice sleep?" Our faces were washed, temperatures taken, and teeth brushed; and then we were left to lie in the dark in disgruntled resentment until breakfast trays appeared about 7:15. This I was to find was the routine early morning procedure. On succeeding days when my incision was so painful that I had to be given sedatives to get any sleep at all, the routine awakening went on without change.

I felt that I was well treated in the operating room. The anesthetic was skillfully administered and there seemed to be adequate help to care for all the necessary preparations. I was most thoroughly scrubbed. I am also glad to record that the difficult operation was very successful and I was very pleased with my doctor's skill and courtesy.

When I woke up sometime after noon, the responsibility for my care evidently had been largely shifted to the friend who was sitting at my bedside. Fortunately for me she is a sympathetic and capable person, but I rather think that was imposing on her good nature. Nobody on the nursing staff watched me, as it seems to me certainly should be done for postoperative cases. When I was nauseated it was my friend who had to do the "mopping up." During two hours or more in the afternoon while my friend stayed with me, no graduate nurse was in evidence. The student nurse on duty was too rushed to answer bells promptly.

The division of labor in this hospital has been carried to almost annoying extremes. All morning long there is a steady succession of persons in the ward. A maid comes in to sweep gingerly under the beds, a porter then mops up with a chlorine solution, another charwoman wipes window sills, furniture tops, carries out newspapers and débris and looks after the flowers. Every patient in our ward belonged on a different doctor's service so there were visits by several sets of interns and sometimes by the doctors, too. Of course the nurses were in many times to give baths, make beds and do other routine tasks. The head nurse also looked in every morning. I suppose they could be commended for getting the "housework" out of the way in the morning, but it is rather hectic and nerve racking to have so many people in and out.

In the afternoon, by contrast, there seemed to be almost no one on the floor. Calls were answered very slowly — a half-hour wait was quite frequent and longer waits not unknown. The main exception to this was that the nurse always arrived during visiting hours to take the pulse and temperature!

I realize, of course, that doctors and nurses are so accustomed to seeing diseased conditions of various kinds that they forget how people without their background react to what they consider routine procedures. In my ward one day, for example, they decided to remove the stitches from a woman who had had an operation for breast tumor. They brought in the dressing wagon and went gaily to it without even putting up a screen around her bed!

This frank statement made by an educated, refined woman who spent a week in a four-bed ward in a well known metropolitan hospital, is presented for its suggestive value. Of course she records only an individual experience which might never be duplicated. Yet we should welcome such thoughtful comments on our work

Another Word on the Volunteer

By CONSTANCE REYNOLDS BELIN
Chairman, Junior Social Service Committee, Hahnemann Hospital, Scranton, Pa.

When the directress of nurses entertained the graduating nurses and their friends at Hahnemann Hospital, Scranton, Pa., tea table talk turned to the subject of social service. From this conversation sprang the hospital's junior social service committee

THE tremendous increase in attendance at the dispensary of the Hahnemann Hospital, Scranton, Pa., had multiplied for the trained workers tedious details that could easily be done by untrained or volunteer workers. A surety that this increase would grow, rather than become less, resulted in the organization of the Junior Social Service Committee.

In choosing the members of this committee, the necessity for workers of proved merit was counted the primary consideration, for it was felt that if the hospital was to benefit their dependability must be unquestionable. Other groups of young women had at various times volunteered their services but their efforts had been so sporadic that they had been detrimental rather than beneficial to the hospital.

With this warning in mind four young women of acknowledged reliability as volunteer workers were selected from each of the larger denominational groups in the city. The number was increased to twenty-five by the addition of those already known to the board as interested in the hospital and having time to work for it. It was decided that no members of doctors' families should be eligible for membership. To these twenty-five hand picked young women a letter was sent by the board inviting them to become charter members.

At the organization meeting of the committee two members of the board presided and announced the officers chosen by the board to head the committee. A set of by-laws, drawn up by the board, was presented, explained and voted upon. Superintendent L. R. Robbins spoke on the reasons for organizing the committee, the benefits the hospital hoped to gain from its efforts and what its aims and ideals should be.

According to the by-laws, the purpose is the "carrying on of such philanthropic activities in

At the dispensary clinics the members of the junior social service committee assist with the clerical work, getting out patients' charts from the files and entering new information.

connection with the hospital and dispensary as are a part of efficient modern hospital service." It was early decided that work in the hospital, rather than efforts toward raising funds, should be the primary interest of this group. In this way trained employees could be released from the necessity of attending to details that untrained volunteers could do.

Membership Kept at Twenty-Five

That this committee might continue active, provision was made for three subdivisions: an active group, a reserve group and an alternate group. The active division is self-explanatory. The reserve class cares for those who are unavoidably compelled to become temporarily inactive. A member may remain inactive for one year only. The alternate group is composed of those who have served two months' probation, but because of the limited membership have not yet been admitted to the active list. When a member is compelled to leave the active list and join the reserve group, her place is taken by a worker from the alternate division. In this way the reserve and alternate groups balance one another and the active membership is kept always at twenty-five.

Each member of the committee devotes one day a week for two months to one type of work and then is released from constant duty, although she must act as a substitute whenever called. Later in the year she works for another two months in another division. In this way no one is overburdened and a freshness of interest is maintained. So successful has this arrangement been that it is not unusual for members to request extra work. It is gratifying to find in a volunteer organization an enthusiasm that is sustained after the first year.

Once a month the chairman submits a written report to the board of directors concerning the activities of the committee. She also advises the board of any new projects that the volunteers plan to undertake. This contact between the board and the committee is further strengthened by the fact that any board member may attend any committee meeting. The officers of the committee maintain close cooperation with the superintendent of the hospital and the head of the dispensary. In this way the hospital regulates the volunteer's work.

This work may be divided into four groups. First are the duties in the dispensary, which are mainly clerical—getting charts of old patients out of the files and entering new information; taking partial histories of new patients; conducting patients to the laboratory or x-ray rooms; taking prescriptions to the pharmacy; making patients stay in their places in the waiting rooms and advising them when their turns in the clinics are coming, and, when requested by the doctors, doing clerical work in the clinics themselves.

The second duty consists of circulating a library on wheels among the ward and private patients. Books, magazines, puzzles and playing cards are distributed to all who desire them. Not infrequently private patients, pleased by this attention, offer to pay for the loan of a book. The volunteer assures them that it gives the hospital great pleasure to provide this service to its patients.

The third division of activity is a story-telling hour for the children's ward. Since this work is a recent undertaking no report can be made of it, but it is hoped that it will provide both entertainment and repose for the children. Once a year a children's party is given, usually on St. Valentine's Day.

The fourth class of work is the motor service. This consists of driving the social worker on her investigating calls. Formerly she was compelled to depend on trolley service and the hospital truck, for the size of the hospital (125 beds) did not warrant the maintenance of a car for her use. Transportation by the committee has been valuable in fitting more minutes into her crowded hours.

Sixty Hours of Work a Month

That the junior social service committee has proved its worth to the hospital is shown by the steady increase in its activities. In its beginning, the committee undertook to work in the dispensary on but two mornings a week. A year later the hospital requested volunteer help on two more days. The story-telling hour is a new development and the library on wheels is an activity not included in the original program. As new opportunities for usefulness present themselves and as the committee develops, more ambitious fields of effort will be entered. The committee now averages over sixty hours of work a month.

As a means of bringing the hospital before the public, the committee fills, in part, a need felt by most hospitals. The enthusiasm of volunteers who are active workers cannot fail to infect those to whom they speak.

As a training ground for future board members, the junior social service committee has already shown it has something to contribute. The board can readily appraise the worth of those who by their work have shown themselves vitally interested in the hospital. Any organization welcomes a new member with a working knowledge of the institution. Since at each meeting of the committee a supervisor or department head gives a fifteen-minute talk, the members are made acquainted with aspects of the hospital about which they have no first-hand information.

Crusading for the Chronically Sick

By S. S. GOLDWATER, M.D.
Commissioner, Department of Hospitals, New York City

Doctor Goldwater believes that America's greatest city should not only solve its own hospital problems but also stand ready to help other cities. Accordingly in this nationally broadcast radio address, which inaugurates a campaign for adequate and humane care of the chronic sick in New York, he offers assistance to any other city which wishes to attack this problem. Here is a good theme for National Hospital Day addresses

CHRONIC diseases are growing at a rate which suggests that America may some day become essentially a nation of invalids. If, as students of history claim, national downfall is the inevitable lot of a devitalized people, it is incumbent on health departments and the medical profession to try to prevent the further physical deterioration of our people. This is possible only through proper hospitalization of the chronically ill and the development of research in this field, too long neglected by organized medicine.

Great progress has been made in the last thirty years in checking contagious diseases and other ailments of childhood. We live longer, but we do not grow stronger. In New York City, which fairly reflects conditions throughout the nation, the death rate from all causes fell from 29.25 per thousand of the population in 1868 to 10.92 per thousand of the population in 1931. But chronic diseases, which in 1870 caused only one-fifteenth of all recorded deaths now account for more than half of the total mortality. The hospitalization of chronics has grown correspondingly, so that today more than 50 per cent of the hospital beds in the United States are at any one time occupied by patients suffering from chronic physical and mental disorders.

Why the Problem Is Complex

There are a number of simple reasons why hospitalization for chronics presents a particularly difficult problem. Each chronic patient must be hospitalized not for a few days, as is the case in acute diseases, but for months or years. This raises the cost of individual service to staggering figures. The chronically ill patient can seldom pay for his hospital care. Voluntary or privately supported hospitals, finding that the admission of a single chronic case compels them to exclude three, five, or ten acute cases, prefer to limit their service to the treatment of acute or short-time illnesses, and the chronically ill patient is forced to turn to the government.

In general hospitals, whose facilities are devoted almost wholly to the care of acute diseases, the average length of a patient's stay is only fourteen days, but in New York City's municipal hospitals, which represent a mixture of acute and chronic services, the average length of treatment for each patient in the combined hospital system is twenty-three days. Patients suffering from such chronic conditions as heart disease, diseases of the nervous system, rheumatism, diseases of the kidneys, glandular disturbances, drug addiction, orthopedic diseases, diabetes and cancer are guests of the city for months at a time, in some cases for years.

I can refer here only briefly to the most troublesome and costly of all chronic diseases, namely, mental disease. For nervous and mental cases the United States has provided, chiefly in state institutions, a total of 513,000 beds. The most striking thing about mental hospitals is their startling growth from 373,000 beds in 1927 to 513,000 beds in 1933. Project this curve of growth into the future for twenty years more and instead of half a million mental hospital cases, we shall have a million. If we do not wish to see a million Americans in mental hospitals in 1955 we must vigorously support every social agency, every educational committee and every medical group studying the problem of mental hygiene for children and adolescents, for it is during these critical early years that the mental future of individuals is to a great extent determined.

Next to mental diseases, the largest definite provision for a special class of chronic cases is the provision for the tuberculous. The capacity of hospitals and sanatoriums in the United States for

persons with this disease is 70,000 beds. Tuberculosis admissions in 1934 were 82,000 as compared with only 50,000 in 1927. Two years ago the American Medical Association began a survey of tuberculosis hospitalization. There are reasons to believe the results of this survey will show the need of facilities greatly in excess of those now available. The collapse method of treating tuberculosis of the lungs is now widely and increasingly used. Active treatment of this kind which tends to displace the relatively passive and prolonged treatment that relied chiefly upon rest, nutrition and fresh air, permits general hospitals to participate more actively in the treatment of this disease.

The Stepchildren of Medicine

In the related question of private medical practice, physicians testify that with contagious diseases under effective control and mothers constantly acquiring an increasing mastery of the hygiene of infancy and childhood, private practice is becoming more and more an affair of the treatment of chronic diseases. We know that chronic disease incapacitates most of its victims and impoverishes many of them. If the physician must live on this type of practice his financial outlook is far from bright. The great mass of sufferers from chronic disease are persons with slender incomes, and for them three lines of conduct are open. They can patiently endure their misery without making any serious effort to obtain relief; they can accept such treatment as a crowded and overworked free dispensary offers, or they can seek admission to a hospital which is willing to accept chronic cases (or which is forced to do so because of its public character). What happens to them then is not a particularly inspiring story, for, as doctors and social workers both know, chronic hospitals are the neglected stepchildren of organized medicine.

Speaking for New York City, I confess that what we are doing for our chronically ill patients is far from enough. Our chronic disease hospitals occupy antiquated buildings which should be replaced. Their laboratory facilities are inadequate. Their resident medical and nursing staffs are insufficient to ensure a full measure of kindly and efficient care. I believe I am justified in saying that not only in New York, but throughout the country, similar conditions prevail.

Clinically speaking, the familiar type of chronic hospital presents a miscellany of chronic cases superficially observed and relatively neglected. The conditions in these hospitals are certainly not such as to elicit the best efforts of the medical staff. Picture the mental reaction of a physician who is confronted with a score of puzzling problems at one time, and who has no means at his disposal for the serious consideration or concentrated study of any one of them. He is so overcome by a sense of his helplessness that he is more than likely to shrug his shoulders and content himself with prescribing placebos.

From his contact with a great mass of institutionally undifferentiated clinical cases the physician learns almost nothing. I am absolutely sure that the defeatist attitude of most physicians toward chronic disease hospitals would change completely if the cases could be sorted out and classified so as to facilitate close observation and study. If anywhere in the United States there is a community that is handling this problem satisfactorily, I should like to know of it.

We must not look to private philanthropy for the solution of the problem. Private philanthropy can help, and in New York City it has helped by sponsoring at least one general hospital for chronic diseases which aims at scientific treatment rather than mere custodial care, but the problem is so vast that nothing less than a government sponsored program will suffice.

A Program Is Outlined

I shall try to state briefly the essentials of a community program for dealing with chronic diseases, and I ask its consideration by every city in the country which accepts the principle of public responsibility for the care of its sick. Mary C. Jarrett of the Welfare Council of New York City has outlined, with the aid of an expert medical committee, a method of approach which the Department of Hospitals of New York City has adopted as its own. It is, I believe, as applicable to the needs of Philadelphia, St. Louis, Des Moines or any large city as to those of New York. This is the program:

1. It is assumed that society has the same responsibility for the chronically ill as it has for the acutely ill.

2. Every responsible public health official must be made to see that chronic disease, with its resultant disability, suffering and economic loss, constitutes a great uncultivated field for profitable public health work. Public health education is making remarkable progress in the special field of cancer. Why not extend the program of public health education to other chronic diseases?

3. In a strictly scientific spirit we should try to find out exactly how social and economic factors contribute to chronic illness. We should ascertain whether the crippling effects of chronic disease can be lessened by reasonable and feasible improvements in the conditions of living and working.

4. We must cease throwing every imaginable type of chronically ill patient into the hopper of

an unclassified hospital service, for this is the very essence of the problem of proper hospitalization for the chronically ill. Confusion, frustration and despair are the inevitable results of so insensate a policy. Intelligent classification is indispensable to close and useful study. Without such study we cannot hope to improve our methods of treatment.

5. Different forms of chronic disease require specialized measures of prevention and treatment.

6. A spirit of inquiry must be fostered and money must be found for the support of intelligently planned research projects.

7. To lavish all our resources on acute illness, while we neglect the chronically ill, is neither wise nor just. Many communities inconsistently spend millions for the construction and maintenance of hospitals for the acutely ill while begrudging even small sums for the care of chronics. Neglected, dilapidated, hopeless in outlook, the chronic hospital often arouses a feeling of repugnance if not one of downright disgust. We must change all this by making the chronic hospital a center for medical research in its special and transcendently important field.

8. Homes for incurables should restrict their activities to the nursing and attendant care of suitable cases. No one should be admitted to such a home without an adequate qualifying diagnosis. A mistaken diagnosis may be equivalent to signing the patient's death warrant.

9. Every home for the aged should have a medical service sufficient for its daily needs and should be closely affiliated with a well organized chronic hospital which is equipped for all emergencies.

10. Chronic disease affects children as well as adults, and it is necessary to differentiate the physical, mental and social factors which affect childhood, youth, middle age and old age.

11. Since mental factors play an important rôle in the causation of chronic disease, an effort should be made to integrate mental health services with medical services in the study and treatment of chronic diseases.

12. From improved methods of treatment we may safely anticipate a shorter average length of hospital stay, a diminution of suffering, and a lessening of physical incapacity. There is another way in which the hospitalization of the chronically ill may be reduced and that is through increasing the facilities for home medical care. Care at home is the happiest solution for the patient and his family in many cases.

I ask you to consider whether your city is doing its duty by the chronically sick. What does your family doctor think about it? Is your pastor satisfied with existing conditions? I urge the Rotary clubs and women's clubs and civic organizations generally to demand appropriate action by the medical profession which, up to the present time, has signally failed to discharge its responsibilities toward the chronically sick.

My last word is an offer of cooperation. Any local organization that wants help in undertaking the study of an adequate community program for the care of the chronically ill is invited to write to the Department of Hospitals, New York City.

Light Absorption of Colors

The color of walls and ceilings has a direct influence on light. The darker colors require greater wattage. Light tinted ceilings and walls, therefore, not only contribute to the cheerfulness of the surroundings but also save money in electric current consumption.

Below are data giving the light absorption of various colors. They were prepared by Hygrade Sylvania Corporation, Salem, Mass.

The following list gives the amount of light absorbed by opaque materials having normally flat colored surfaces:

White } Ivory }	20 per cent
Ivory	29 per cent
Primrose yellow	22 per cent
Gray (depending on tints)	30-80 per cent
Buff	36 per cent
Pink	46 per cent
Azure blue	60 per cent
Sky blue	63 per cent
Tan	65 per cent
Olive green	79 per cent
Forest green	80 per cent
Cardinal red	80 per cent
Brown	81 per cent
Dark green	95 per cent
Dark blue	96 per cent
Black	99 per cent

Saving Time for Physicians

A physician or nurse attached to any hospital, dispensary or other charitable institution in New York State cannot be subpœnaed to testify in court regarding a case treated in such institution without a special order from the judge of the case, according to Emmanuel Hayt, member of the New York bar, writing in the *New York Physician*. Instead, the Civil Practice Act of the state provides (Section 354) that the testimony of such a person shall be taken by a referee appointed by the judge. This provision enables hospital physicians to avoid substantial loss of time waiting to testify in court regarding cases they have treated in the hospital. It is a provision that might well be adopted in other states.

Meeting with one express purpose, to help their hospital, members of the twenty-nine women's organizations in the Horton Memorial auxiliary have their own room on the first floor equipped with a long work table.

Its Auxiliary Is Hospital's Strength

By RAYMOND P. SLOAN
Associate Editor, The MODERN HOSPITAL

THERE are two approaches to the Elizabeth A. Horton Memorial Hospital at Middletown, N. Y. One is by the lower road from which the visitor can, if he is so inclined, reach the main entrance by a flight of stone stairs. The other, and more customary way, is to take the driveway which makes easier the sharp climb up the slope to the three-story brick building perched at the summit of the hill. Like a beacon it stands, its windows shining in the warm rays of a spring sun, reflecting light upon the town below. As a true beacon, it serves in guiding the populace along safe channels of better health, happiness and sane living.

To familiarize himself with the setting, the visitor takes the more devious route up the stone steps to the hospital terraced high above. There could be no better opportunity for brief speculation.

Why should this particular institution be the mecca of a sixty-mile pilgrimage from New York City along circuitous roads, up and down rolling hills and through rich farm lands?

The sound of whirring motor cars comes from above. Drivers drop their passengers at the front entrance and continue on their way — some back to the town, others around to the parking space at one end of the building.

Surely these cannot all be patients! The laughter of women's voices fills the air accompanied by gay chatter and friendly banter. Hardly does it reach the ear before it is gone, thrust by the closing of the massive front door to the tender mercies of the gentle breeze that carries its faint echo down the slope and away.

Perplexed, the visitor turns to facts. Middletown, N. Y. — population between 19,000 and 20,000. The Elizabeth A. Horton Memorial Hospital erected in 1929, representing an investment of $980,000 — endowment today, $580,000 with additional income from a trust fund of $87,000. Bed capacity, ninety-two and eighteen bassinets.

Last year's figures — income from endowment,

$26,000; expenses, not including depreciation, $134,000; income from patients, $107,000. Closed year with $1,200 loss.

Further consideration of these facts is interrupted by additional arrivals above. Again the closing of automobile doors, the exchange of friendly greetings, then silence. No need to waste further time in speculation. The visitor climbs the remaining stairs, crosses the drive and enters.

No gala occasion awaits him. Everything inside is in line with usual hospital procedure. Inquiry at the desk reveals merely the presence of one of the twenty-nine women's organizations in the hospital's auxiliary, meeting as they do once a month to make dressings, cotton balls, replenish or repair the linen supply and uniforms, and arrange for other equipment for which they are held responsible. Practically every afternoon one of these groups meets to work for the hospital.

They have their own room on the first floor, especially equipped with a long work table and comfortable chairs. Books line the walls, comprising a lending library for patients. In one corner a book cart stands ready to be rolled through the wards and private rooms — another activity supervised by the women's auxiliary. Bright sunshine streaming through the windows is made even brighter by the chintz hangings, further evidence of the work of these staunch hospital friends.

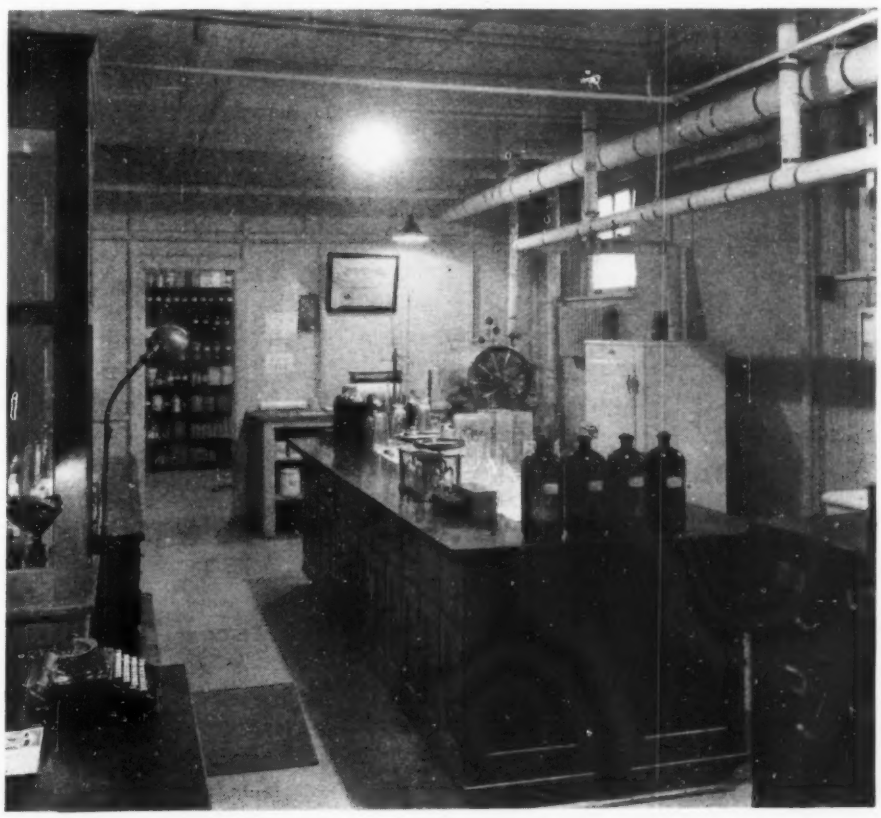
The strength of Horton Memorial lies in its auxiliary organization. There are few homes in Middletown that it does not reach in one way or another. Support of the hospital does not rest, therefore, with the chosen few comprising its directorate, but with the community at large. Each and all play a part, no matter how small, and contribute according to their individual abilities.

This auxiliary organization has been developed during the past six years. When the hospital was opened in 1929, there were no community groups on which it might call. The first steps in this direction took place when a merger was effected between Horton and Thrall Hospital, also of Middletown. This latter institution had what were known as a Lenten Club and a Thimble Charity, comprising groups of women who met now and then to sew for the hospital and raise what money they could.

From its very start Horton Memorial was destined to belong to the community. Under the able guidance of Dr. Arthur S. Moore, superintendent, who even a year before it actually opened was engaged in laying a solid foundation for the hospital's future growth, a definite plan of community relations was formulated. All existing organizations in Middletown were invited as organizations to join the hospital auxiliary, irrespective of religious beliefs or political affiliations, and to appoint or elect a representative on the auxiliary board.

Today 150 societies or associations are members of the Horton Hospital auxiliary. Each of these groups pays $1 yearly as dues entitling it to have a representative. From among these representatives an executive committee is appointed consisting of seven officers and four committeemen at large who conduct the affairs of the auxiliary. In addition, there are fifteen standing committees.

The speakers committee, for example, numbers eighteen. It is the function of this particular group to supply speakers for the various organizations,



Substantial economies result from activities in the modern pharmacy where preparations are made and put away for future use.

and to keep information pertaining to the work of the hospital before the entire community at all times. Doctor Moore furnishes this committee with figures and statistics once every three months so that it will always have on hand the latest facts.

Each year when Hospital Appeal Week is observed, usually some time in February, the speakers committee appoints minute men to address organizations and groups on the hospital's needs and help raise funds to meet deficits. Subscriptions and gifts for Donation Day held at Thanksgiving time are solicited in the same manner.

Four times each year the representatives of the 150 organization members of the auxiliary meet, bringing with them other members, also friends and relatives. Sometimes an audience of two hundred or more assemble to hear a talk delivered by some nationally known hospital speaker.

The interest thus aroused in hospital affairs assures adequate support for every activity. Three members of the auxiliary group have even been appointed to the board of directors.

It will not be long before Horton Memorial will have its own group hospitalization plan operating under the name of the Horton Hospital Service Corp. This is now before the state department of public welfare and the state superintendent of insurance. If approved, it will be controlled by a board of twelve members, comprising six from the hospital board, four from the auxiliary and two from the medical staff. The organization with which to carry on the work exists already in the auxiliary. What could be more logical than to turn over to the speakers committee all responsibility involved in presenting the details of the plan before industrial groups?

What $.80 a Month Will Provide

Enrollment in this hospitalization plan requires the sum of $9 paid annually or in semiannual or quarterly payments. The monthly charge is $.80. This provides three weeks of hospital care in the wards and a discount of 25 per cent on any longer service. It also includes a 25 per cent discount on out-patient, diagnostic, laboratory and x-ray work.

This last feature of the plan is significant in that it is typical of the policy that has always existed at Horton Memorial of spreading into the community. It was not organized to serve merely the sick but to cover a wider field as a reference hospital and to assume leadership in medical affairs. The institution was fortunate in having during its formative years the help of Dr. Joseph G. Yocum, identified for many years with the Skin and Cancer Hospital of New York, who was responsible in a large measure for the formulation of its standards and policies. Doctor Yocum served on the board of directors from 1919 until December of last year when his death came as an irreparable loss to the institution.

Despite the fact that the hospital started to function in 1929, it was in 1916 that Eugene Horton first established a fund of $100,000 for its construction and an additional $500,000 for its endowment. This fund was found to be insufficient. By 1925 and 1926, however, the amount designated for construction had increased to nearly $450,000 which with additional gifts made possible an investment of $980,000.

Internal Management Is Sound

The strength of Horton Memorial lies in its auxiliary organization, to be sure, yet the strength of any institution as noted on the outside must reflect equally sound organization within. In this respect Horton Memorial is no exception. It is as strong within as without, as is manifest by the figures covering last year's operation when conditions were extremely discouraging. The effects of the depression were not felt in Middletown until 1932 but from that time to the present day bad times have left a heavy imprint on the countryside.

Before considering how Doctor Moore and his staff, ably abetted by a loyal and active group of trustees, have carried on during a year of depression with a loss of but $1,200, certain facts should be considered. The hospital draws 49 per cent of its patients from Middletown, 24 per cent from Orange County and 27 per cent outside of Orange County.

Its attending staff comprises fourteen men. There is a full-time doctor on x-ray and laboratory, a full-time x-ray technician, and two full-time laboratory technicians. Two resident physicians are employed at salaries ranging from $105 to $115 monthly and maintenance.

Further evidence of the hospital's participation in community life is evidenced by the fact that all but four local doctors are on the courtesy staff. That the hospital has also fulfilled its function of raising medical standards is revealed in the presence today of five or six American College of Surgeons men whereas six years ago there was but one. Also significant is the number of local physicians who are taking postgraduate work.

Clinical work has expanded as might be expected. Only recently a diagnostic heart clinic has been added to those already established such as eye, ear, nose and throat, surgical, prenatal, postnatal, sick baby and tumor clinics.

Employees on the pay roll number seventy-four. The ratio of employees to patients is about 1 to 1.42. Also significant is the practically negligible

turnover in the personnel. Eighty-four per cent of the help now engaged have been working in the hospital for five years.

The dietary department accounts for fourteen. Two maintenance men are required for work outside as well as inside the building, since the hospital's property covers about twelve acres. There is a boiler room crew of three, and four assistants are required in the laundry.

The two orderlies are male nurses, graduates of the Middletown State Hospital. Their presence has overcome many of the problems encountered in handling this type of help. Incidentally, their knowledge and training in the treatment of mental cases have been found helpful in coping with difficult situations caused by delirious patients.

There it stands—the Elizabeth A. Horton Memorial Hospital on the summit of the hill—a beacon lightening the darkness and guiding the populace of Middletown, N. Y., along safe channels of better health, happiness and sane living.

Twenty-eight registered nurses are employed. This marks a change in the hospital organization and deserves first place in notes on economies achieved. Last year the nurses' training school was abandoned. It was found that there were too many nurses in the community. The overhead in maintaining a proper teaching staff was considered too great for the small number enrolled. A saving of $5,500 during the year is estimated as the result of employing graduate nurses only. About 50 per cent of the girls now employed are the hospital's own graduates.

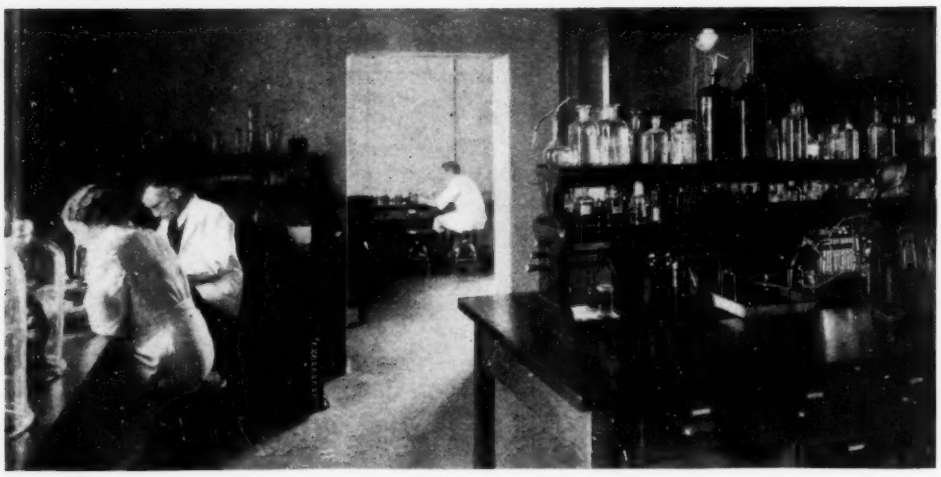
Reference has already been made to income accruing from patients which during the past year amounted to $107,000. This is repeated because of its very direct bearing upon charges for hospital care, credit checkings and collection methods.

The hospital makes a flat charge for all services. Ward accommodations are $4.40 daily; a semiprivate bed costs $6.60, and private rooms range from $7.70 to $8.80. When a patient pays for one week, these rates include all charges for laboratory and x-ray work, electrotherapy treatment, dressings and routine medicines. They do not include charges for physician's services, operating room service, board for special nurses and anesthesia.

Maternity cases are treated in the ward for $55 for a ten-day period, in a semiprivate room for $66 and $77 covering the same length of stay, and in private accommodations for $99 and $132 for a similar period. These rates include all charges for delivery room, care of the infant, dressings and other routine services. For families with small incomes, a three-day stay in the hospital is provided with complete care, and one week of follow-up service in the home for $27.50.

The financial standing of each patient entering the hospital is carefully checked through the nearest relative or friend. A printed statement is provided where all pertinent information is listed as a record. Should the patient acknowledge his inability to pay the full sum, he is privileged to fill out a form agreeing to pay the hospital in installments. In the event of his failure to make the payments as agreed, he is charged with interest upon all sums remaining unpaid and an additional collection charge of 15 per cent. Doctor Moore reports some paying as little as fifty cents a month.

It is our privilege to examine one month's reports and to note results. During this particular month 107 patients were discharged. Sixty-two of them paid in full. Fifteen were on welfare or compensation insurance, and twenty-two signed installment agreements leaving eight unaccounted for. Four of these were deaths in which claims will be made upon the estates. Three of the remaining four were members of the same family, a mother and two children all suffering from an



Elizabeth A. Horton was not organized to serve merely the sick but to cover a wider field as a reference hospital and to assume a leadership in medical affairs as is revealed by the modern laboratory.

acute infection. One of the children died. The other was discharged, but the mother is still confined to the hospital. She will meet her obligations when able to do so. Surely then, one patient out of 107 is an enviable record!

Abandoning the nurses' training school has resulted in the biggest saving accrued during the past year but when all is said and done, it is the little things that count. The greatest care has been exercised at Horton Memorial during the past year or two in controlling waste and needless expense. It is to the great credit of the personnel that so much has been accomplished because of individual cooperation. Hardly a week passes, according to Doctor Moore, without someone coming to his office with a suggestion for economy.

Last year, for example, food prices went up 21 per cent. Food costs on the other hand, meaning patient day cost for raw food, went up only 10.2 per cent. The answer is apparent — careful planning and buying. There are certain foods the dietitian frankly confesses she will not buy at present prices, particularly those which have no great appeal to the patient. Yet — other dietitians kindly note — no complaint has been received on food served at Horton Memorial during the past three or four months.

The war on waste in the dietetic department has actually resulted in additional income. Leftovers, such as desserts served with whipped cream which will not keep, also remaining slices of pie and cake are sold to employees for a few cents. Particularly those who are themselves housekeepers are glad to take advantage of such opportunities and sometimes twelve or fifteen dollars a month is added to the hospital exchequer in consequence.

Exemplifying the spirit of cooperation on the part of the hospital employees, kitchen breakage during the first three years ran as high as $20 or $25 a month. Now it averages $6.

The campaign to reduce overhead has eliminated many so-called luxury positions. The hospital does without the services of a hostess and ushers. There has been found to be no apparent need for a house mother in the nurses' home. Each one serves as his own elevator operator without incurring any hardship, the building having but three stories.

The de luxe private corner rooms were in little demand, so two beds were placed in them, thus increasing the bed capacity and still making possible luxurious accommodations at lower rates.

Sheets, it was discovered, could easily be cut down three times. When it seems expedient to do so the full size sheet is transformed into a children's bed sheet. Next it makes its appearance in bassinet size.

In making ordinary dressing compacts ten layers of absorbent wadding are now used instead of twelve. The wattage on lights has been cut down throughout the building. Motors are shut off here and there when their services are not urgently required. In the pharmacy various preparations are made and stored away by the hospital's own pharmacist at great saving.

Yet in no department is economy achieved at any sacrifice to service. Downstairs two modern ambulances attest to the hospital's activities along New York's vast highways. Every call is answered by a doctor, a nurse specially trained for such service and a driver who also is qualified to assist.

The pilgrimage is at an end. The main door opens revealing an extensive panorama of house tops with an occasional church steeple reaching up into the darkening skies made even more somber by lazy puffs of smoke drifting upward from factory chimneys. Lights begin to flicker here and there in the valley.

Again the sound of women's voices, coming from within. This time the talk is of gauze, bandages, packings. These faithful workers walk to their cars and drive away. Soon when the family circle is complete about the supper table and the fireside there will be further talk of the hospital and of the work it is doing for the community.

What the Hospital Owes the Intern*

Interns are required by law to spend many months in a hospital. Is your institution indifferent to these young men? Do you consider that they know only theory when they come to you, that the finest equipment is useless to them unless there is someone to demonstrate its uses? Does your hospital give them full value?

THE responsibility of the hospital to the intern is second only to its responsibility to the patient. While much improvement in the character of internships has resulted from the continued insistence of medical and surgical associations upon certain standards, the actual task of providing the required postgraduate course, with those elements that permit the intern to leave his service having received from it what he needed and wanted, still devolves almost entirely upon the individual hospital.

Let us glance for a moment at what the intern has a right to receive, and at what, only too often, he does receive from the hospital in which he spends his postgraduate year. He expects to be allowed to put into practical use the half learned or often wholly forgotten general principles in the treatment and diagnosis of disease of his undergraduate days. During the short period intervening between his final examinations and graduation, much of this didactic information has become rather hazy to him. It is probable that the physician's practice is based more upon his observations of treatment made in the hospital than upon information received during his college days.

The intern learns by observing what others do and by doing himself. He requires thorough and constant supervision during his hospital days, but rarely receives it. During the all too hurried visits of his chief he should and does secure much valued information relative to the treatment of the sick, yet much of his instruction comes from a resident physician or from his own associates who are just beginning their second year of internship.

Too often this teaching is given only by word of mouth. Rarely is he given a typewritten brochure fully acquainting him with the methods in vogue in the hospital in which he is serving. He takes a clearer and more complete history during the first few months of his internship than he ever will again, in this respect he is more skilled than the chief himself or his associates, but he is not able to organize his knowledge and has had no experience upon which to draw in selecting the treatment most efficacious for the individual patient under his care. His chief, perhaps too ready to criticize, is too busy to instruct.

The intern expects a carefully considered and graded course of instruction which is fitted to his developing capabilities. In most institutions some sort of intern schedule has been adopted. Too frequently, however, such schedules smack of carelessness and lack pedagogic skill. In a classical course the freshman is not required to perform the same tasks as the senior, but as his intellectual abilities develop he is led forward until his training culminates on graduation day. Such a sound arrangement is often absent in the intern course.

Do You Expect the Impossible?

The new intern on his first day in the institution is sometimes expected to perform tasks of which he is entirely incapable. He attempts the impossible when he is assigned to assist at a major operation, or perform ward dressings, or carry out minor medical surgery. It is unfair both to the intern and to the patient when a recent graduate is given full charge in a busy accident ward. It is the exception rather than the rule for a carefully considered course of instruction to be given the new intern before he is permitted or required to assume serious responsibilities. Not infrequently the young intern is informed that his duties on the first day consist of such steps as taking blood for serology, performing extensive surgical dressings, taking throat cultures or counting blood. These procedures later will be simplicity itself to the same young physician, yet on his first day or even during his first few weeks in the hospital they represent decidedly major procedures.

That hospital which does not take into full consideration the new intern's inexperience, his abject terror of being required to assume responsibility for which he is not prepared is falling far short of

*Practical Administrative Problems Series.

properly planning for a well rounded training course. The first few days of the intern's life in a hospital should be largely given over to didactic instruction and practical demonstrations of methods employed in the practice of institutional medicine. A chief resident physician and a selected group of associates or assistants on the visiting staff may make up this faculty.

When the necessary capabilities have been acquired to enable an intern safely to assume other and greater responsibilities, then and only then should they be imposed upon him. Incidentally it may be remarked that throughout the whole intern course, this spirit of demonstration and instruction should be carried on. It is unfair to the patient as well as to the intern to permit him to attempt a blood transfusion without having been first fully instructed as to the best methods to employ. A clinic on the needling of chests and of peritoneal and pericardial cavities, at which all interns are required to be present, might well be held.

The first obligation of the hospital is to furnish good care for the sick. Efficient treatment of the sick is bound as a by-product to produce valuable training for nurses and interns. It is impossible for either of these considerations to be successfully attained without time and effort being spent in didactic instruction before the practical application of such methods is permitted.

The intern expects instruction in the art of practicing medicine. He receives little if any training during his collegiate course pertaining to his personal conduct in the presence of the sick. Most curriculums are too largely concerned with the frantic endeavor to prepare the young doctor for the diagnosis and treatment of disease to take into consideration that physicians who are inhumane, inconsiderate or unkind to those persons who happen to be possessed of diseased hearts or deranged livers cannot render good medical service.

Medical Skill Alone Doesn't Bring Success

If he does not receive the proper training in his medical college as to bedside conduct, he surely should be given the opportunity of learning about these things which, to an even greater degree than an absence or presence of unusual medical skill, will determine his success in the practice of his profession. Examples of good conduct should be set him by his chiefs. Watching them, he should learn to refrain from discussing prognosis and diagnosis in the presence of terrified patients, and he should learn the value of kindliness. He should be instructed as to the best methods of examining a female patient without embarrassment to her. He should be taught the effect of sickness upon personality and told of the importance of understanding the psychology of the members of the patient's family.

How may all of these requirements be set down in an intern's schedule? What are the practical methods for organizing a program that will begin with the performance of simple procedures, and add as it progresses to the young house officer's responsibilities until the full period of service is completed? The building of an intern schedule is not a simple task. Its nature depends upon the size of the hospital and the scope of the work performed in its departments. Nevertheless, whether there be two or twenty interns, a course of instruction must be set down in which each duty assigned to the intern is accounted for. No college could long continue without a curriculum. No resident medical service to patients can be adequate without a planned schedule covering each hour of the day's work or at least containing every type of contribution which should be made by the intern to the patient. It should be conceded then, from the start, that all hospitals training interns must have a written curriculum and must strive to adhere to it.

Broad General Experience Essential

There are two usual types of intern service, that which rotates at stated periods and that which contains long assignments to one particular type of work. The former, or rotating service, is conceded by many to be the one best adapted to furnish a well balanced training for the general practitioner in medicine. The hospital intern year is not the time to train specialists. The unit schedule, which assigns the intern during six or more months to medicine or surgery, is better adapted as a foundation for specialization, but no physician should be permitted to specialize without having first broad experience in all branches of medicine.

As to the length of each period and the subjects which it contains, each hospital must be a law unto itself. This is true because the amount of available experience and the number of patients in a department vary. In many states the basic intern year consists of three months' experience in medicine, surgery, obstetrics and laboratory work, respectively. There are, however, many important and necessary duties which the intern must perform that do not strictly fall into the above classification, for ambulance interns are needed, anesthesia must be given, dispensary hours must be covered.

Because so little attention is given to the education of the intern, a clumsy schedule frequently requires his presence in several places at one time. When this happens patients must wait, chiefs become disgruntled and personal friction arises. Anesthesia, dispensary, ambulance and accident ward duties in the small hospital are likely to be

assigned to the intern along with other major obligations. As a result, the intern, legitimately employed elsewhere, is criticized for delay in answering an ambulance call, or some other summons.

An intern schedule drawn up in the manner employed in medical college curriculums where block assignments of duties are set down, is often graphically helpful. A hospital executive who fails to remember that those who wear the white uniform are human beings requiring hours for sleep, time for meals and some recreational opportunities, is likely to be unfair to the young graduate and to fail his patients.

The irascible and demanding chief who insists that the intern be at his side while he gossips with those whom he meets, forgets that while he thus squanders time a patient somewhere is without the service of his intern. This is a curious attitude on the part of some chiefs. To them the intern is something of an automaton, placed in the hospital for the particular benefit of the chiefs.

The length of periods in a rotating service depends upon the amount of material available. The number of interns required is indicated by the number of patients assigned to a particular department. In institutions of size, more than one series of from two to four-month assignments must be worked out. In the largest hospitals experience in every branch cannot be given to each intern. If all of the specialties were given the periods of assignment would necessarily be too short, for, if they were adequate, the total intern course would become too long. This problem is more or less easily solved by conducting several services, each with its subdivisions and each covering the subjects required by the licensing board of the state.

Is Junior and Senior System Desirable?

Whether or not the junior and senior system should be adopted depends upon the size and nature of the hospital. When a service is large and active, two interns or a multiple of this number may be assigned, their services so staggered that the senior will have served two or more months before the junior begins his work in a particular department. This way there is always one or more physicians who understand the scientific workings of the department. Within each department there may be subassignments. The junior intern on surgery may, in addition to his other duties, be expected to care for the laryngologic, genito-urinary or proctologic patients being treated on the service of another chief. If no staff specialists are in the hospital organization and all surgical conditions are treated by the general surgeon, the situation is simplified.

There are some general rules which apply to the building of any intern schedule. It is probably not best for the same intern to treat patients in the maternity division and also assist the general surgeon at operations on infected patients. It certainly is true that the same intern should not perform postmortem examinations and also serve in the surgical or maternity departments. It is questionable whether the intern who treats children in the pediatric department should also care for the infants in the nursery.

It is proper in a twelve-month course to divide services into two or two and one-half month periods if the local state board will permit. When this is done, even though but few interns are in the hospital, a definite time can be assigned to the dispensary, ambulance, accident ward and anesthesia services, without requiring the absence of an intern from the operating room or other department.

Dispensary Work Is Valuable

Too much importance cannot be attached to the value of good dispensary experience. There are those who believe that the experience gained in assisting at major operations is of much less practical value to the intern than is the work which he performs in the accident ward and the dispensary. The danger of permitting the intern to arrive at a belief that surgery is simple, which sometimes follows the experience of learning the feel of the scalpel or of observing the patient recover upon whom he has operated, is that upon the completion of his course he will consider himself capable of performing major surgery.

The presence of the resident system in a hospital is probably a good plan. Here older graduates in medicine are assigned to general departments and thus supervise the interns. There are many extracurricular activities which should be scheduled in the intern course. Periodic lectures to interns, monthly intern and staff conferences, and the holding of scientific meetings by the interns help in giving a well rounded intern experience.

Of the greatest importance to the future of medicine is the case teaching which should emanate from the chiefs themselves. Unfortunately many men of years and experience lack the ability to teach. This is the weakest point in the training of interns the country over. It would be well if inspectorial bodies would turn their attention from the importance of the physical to the absolute necessity of insisting that staffs be educationally minded. Then and only then will graduates in medicine receive what is due them during their intern course. Until and unless this is done, laws requiring one or more years of internship are unfair and oppressive. The American Hospital Association might do well to study the type of training its institutional members give their intern staffs.

Editorials

Fair Play for the Chronically Ill

ATTENTION is directed elsewhere in this issue to the plight of the chronically ill. It is well that this matter has again been so forcibly brought to the consideration of so vast an audience as is possible when the radio is employed as the instrument for disseminating useful information.

The chronic patient represents but the dying embers which remain when the bright flames of acute disease have subsided. When the battle for supremacy between bodily resistance and bacterial virulence becomes a stalemate then chronicity ensues. In the physician, the mere permanence and lack of change of tissue pathology or clinical symptomology, generates lack of interest. Gradually scientific concern in such patients wanes and attempts at a radical cure cease. The economic status of the patient gradually sinking, he finally becomes a charge of a public institution — hopeless, helpless and almost forgotten. If family ties or pride keep him in the home he often brings disaster there, the health and strength of the wage earner being sapped by the necessity of performing arduous nursing duties while at the same time attempting to earn a livelihood.

Few communities care adequately for the chronic patient — none fully appreciates his sorry position. The call has come. It is hoped that such a body as the council of the American Hospital Association will heed, and heeding, will both study the proportions of the problem and at the same time suggest some plan pointing to the solution.

Standards of Nutrition

THERE is something about the term "standardization" to which liberal-minded people do not take readily and of their own free will. It sounds perilously like "regimentation" and is apt to produce a feeling of physical and spiritual limitation among those whom it affects. Any change in circumstances requires an opportunity for self-expression which seems to be denied in the definition.

Standardization of the habits and comforts of life and of individual ways of thinking is one thing, however, and the establishment of improved standards of living is another. Standardization of cultural policies, for example, has something about it that is elevating and is therefore desirable. One need have no anxiety about any plan that will aid in raising the educational level of daily life in this country.

This is all by way of introduction to the various standardization programs that have been elaborated for the benefit of the hospital world by responsible organizations which occupy positions of authority. The American College of Surgeons, the American Medical Association, the American Hospital Association, acting independently or in cooperation with governmental agencies, have had their share in establishing standards of service the progressive tendencies of which have elevated hospitals to higher planes of activity. Every profession and every specialty strives for better things. In the case of hospitals, better service to the sick is involved. The last of those who have put in a plea for our consideration is the American Dietetic Association and its affiliated organizations, which represent the food service rendered in thousands of hospitals in this country.

The most striking work in experimental medicine today is being done on problems which involve the nutritional factor in one form or another. The position which the field of nutrition is coming to occupy in the routine, the educational and the investigative program of the hospital, is a vital one. The personnel selected to manage the food service in the hospital, and to cooperate with the medical staff in the scientific study of food problems, must therefore be selected with the greatest of care. It will not do, as these representative nutritionists warn us, to compromise with low standards in the administration of food service. It does, indeed, require an intelligent and well educated food specialist to deal with and advise on food problems. As in many other fields of endeavor, secondrate schools maintaining inadequate standards have sprung up and flourished. In their eagerness to secure a student body they have been admitting applicants who are not acceptable in the better schools and have been giving them inadequate training for their special work.

It is of interest in this connection to review the educational standards which have been elaborated by the American Dietetic Association. They deserve encouragement, particularly at this stage of the development of the science of nutrition. If hospitals generally will select for the administration of their food departments only those candidates who have met the standard set for them by the organization best fitted to do it in this country, much will be gained. A college training, based on the fundamental biologic sciences, and a full year in a

good hospital are not excessive requirements for a class of workers whom we now expect to contribute so much toward the development of the field of medical and hospital progress.

For the administrator the recognition of these educational standards when he is in the market for a food specialist is one of the easiest ways of raising to higher levels the position which his hospital enjoys in the community. Recognition of this kind will at least exclude inferior types and the tendency to exploit their services which inadequate preparation encourages.

Dr. George H. Bigelow

THE hospital world was shocked to hear of the death of Dr. George H. Bigelow, former director of the Massachusetts General Hospital, who disappeared early in December and whose body was recently recovered. He left behind him a record of magnificent achievement as a public health administrator, and his short term of service in the hospital world justified the prophecy of a brilliant future for him in this field.

His many friends take pride in the fact that his record of accomplishment during his comparatively short years of life will serve as an inspiration to earnest and zealous workers in the field of public health and hospital administration.

The Hospital Number of the J.A.M.A.

IN THE March issue of The MODERN HOSPITAL there appeared a study of the distribution of general hospitals throughout the United States with special attention to rural areas. On the basis of careful analysis of the data it was concluded that many rural areas were seriously undersupplied with hospital facilities to meet the real needs of the people. It was emphasized that this conclusion was based on the needs of the people rather than on their ability to build or support hospitals. Obviously it is unlikely that there will be a lack of hospital facilities in areas where there is plenty of money to build them, where the people can easily afford to patronize them when built and where the local physicians are familiar with hospital service and standards.

The study named ten conditions to which consideration must be given before actually locating a hospital in an area, as follows: "(1) size of population; (2) size of area to be served; (3) density of population; (4) number and training of physicians in the area; (5) extent to which the provision of hospital facilities would improve conditions of medical practice through assisting present practitioners or attracting new ones; (6) distance to other hospitals; (7) road conditions, summer and winter; (8) the health knowledge of the people and the extent to which they could be trained to use hospitals where necessary; (9) the suitability of home conditions for caring for less serious illnesses; (10) financial resources of the population, that is, occupational and income groupings, and the extent to which new methods of paying for medical service may be devised which will facilitate support of rural hospitals." It was further stated that "the question of how the hospitals built in rural areas which are now poorly served would be financially supported is deferred to a later discussion."

Without any mention of the qualifications thus emphasized in the study, an editorial writer for the *Journal of the American Medical Association* has sarcastically attacked the study and also an editorial in the same issue of The MODERN HOSPITAL as "propaganda based on preconceived notions rather than on exact and complete knowledge of the situation." By bringing forward the well known fact that in these neglected areas existing hospitals (many of them small proprietary institutions with a minimum of equipment) are inadequately used, the editorial seeks to prove that there is no insufficiency of hospital service or facilities. By this type of reasoning one could prove that because doctors' incomes have fallen off markedly during the last few years, the health of the people has correspondingly improved.

It is unfortunate that such an attitude should be manifested by the *Journal*, especially in the very issue which is distinguished by so much admirable work by the Council on Medical Education and Hospitals. The statistical summary of hospital activities this year is even better than the high mark established in previous compilations. Several marked improvements have been made in classifications and the addition of maps showing the distribution of hospitals is a distinct contribution to the presentation of the hospital picture.

Blood Tests for Paternity

IN AN Eastern court a distinguished jurist recently ruled that blood agglutination tests were not sufficient proof to justify a jury finding for a plaintiff mother who sought support from a defendant who she contended was the father of her minor son. The search for such a definitive test has been long and exhaustive. There are four blood groups in man denominated by numerals (Moss nomenclature), or, as foreign scientists suggest,

by the letters O, A, B, and A.B. Except for the ape, the blood of wild animals is much more homogeneous than that of man. The typing of blood is almost a daily practice in the hospital. Particularly is this true since the popularity of transfusions has been on the increase. It has been observed that certain patients who have been followed for years retain the same grouping. Indeed, many competent observers state they never have seen a change from one group to another. In suits for inheritances this permanence of a blood group has been employed as evidence.

In a hospital where faulty administrative practices may make possible the interchange of babies, this principle has been evoked to quiet the fears of a distracted mother who suspects that her baby has been changed for another. That the blood type of a mother is usually passed on to the child is disputed by some. Others appear to believe that the paternal and maternal origins of a baby can be determined by modern agglutination methods. Still other investigators believe that the careful microscopic measurements of the blood corpuscles offer some evidence of value along this line. However, in the light of the above court decision, the legal value of such beliefs seems to be clouded.

Who Should Give Permission for an Autopsy?

IT IS usually held that a permission for an autopsy is legal and binding only if it is properly signed by the nearest of kin of the deceased patient. The basis of this opinion is that a body is in fact the property of the estate of the deceased and as such only the legal representative of this estate may give consent for its postmortem examination. That person who purposes to defray the expenses of burial is usually the one who signs the autopsy permission. Yet on rare occasions the patient himself, desiring that an examination of his body be made after death, signs a permission for an autopsy to be performed on his own body. The inference is, of course, that a patient owns his body after life has departed.

It is possible that a properly executed postmortem permission signed by a patient before death takes on the nature of a testamentary document. A person may express in his will a desire for some particular manner of disposal of his body. He may will it to science or he may direct that it be cremated. If he provides funds for the necessary expense incident to carrying out his wishes, such directions are binding and mandatory on those designated as the executors. But if no funds are set aside for burial or if an estate is insolvent or if relatives are unable to provide for the necessary expense of burial, such a request would probably be given little consideration. This is particularly true if such a body were to remain unclaimed.

This interesting angle on postmortem work is not purely theoretical or supposititious but has been encountered on several occasions. The surest method of securing legal permission for the performance of an autopsy is to obtain the written consent of the nearest of kin of the patient. To accept the signature of the patient to an autopsy form in any but very exceptional instances would probably be a serious error of judgment.

What Relief Agencies Do Not Recognize

THE voluntary hospital has in the past been able to fight its own battles. Its financial path has often been thorny and rough. It has neither asked nor received quarter from any agency which would paternalize it. In those comparatively few instances in which it receives state subsidies, it has been able to maintain its self-respect because it gave much free service in excess of that for which it was paid. It has not stultified its soul by yielding to the requests—often veiled demands—of a cheap legislator who sought favors in payment for his vote. It has known full well the blighting effect on the care of the sick which accompanies the touch of a politician's hand.

Governmental bodies may have mistaken this endeavor to maintain self-respect for affluence. Possibly this refusal to pay for the care of indigent patients in the voluntary hospital is but a crafty method of avoiding a just obligation because the charitable traditions of the hospital's past forbid the wilful refusal of aid to the needy. What these public officials do not recognize is that recovery cannot progress when sick bodies and minds are expected to carry their share of the load.

The wheels of industry cannot be profitably turned by ailing hands or those under the control of clouded brains. Figuratively or literally to defy the voluntary hospital, to refuse to accept the indigent for whom relief funds should pay is sheer insolence. Justice to one of the nation's most effective and useful public servants—the voluntary hospital—demands a reconsideration of the stand that those well but indigent are governmental charges while those who are both indigent and sick at once become the responsibility of the voluntary hospital. To adopt such a policy is to attempt to solve the problem by reducing it to an absurdity.

Should the Hospital Make or Buy Its Dressings?

By WALTER MEZGER*

Superintendent, Knickerbocker Hospital, New York City

AN EXPERIMENT was recently conducted to reveal the cost and efficiency of hospital-made dressings as opposed to the ready-made type. The former are obtained by fabricating the various necessary raw materials into dressings and pads in the hospital. The work is done primarily by volunteer groups of women and to some extent by student nurses. Such labor is not directly chargeable inasmuch as it does not involve a cash outlay. Additional time is required for handling and cutting for which there is a direct charge.

In order to make a comparison on an equitable basis it was agreed to use the standard ready-made dressings of a reputable manufacturing concern exclusively throughout the institution over a period of three months. Rather accurate conclusions could then be drawn by comparing experiences of this period with any other three months' period during which hospital-made dressings had been used.

With the able and willing assistance of Elizabeth Hansen, R.N., of the hospital staff and with the cooperation of one of the leading manufacturing companies, current dressings were studied and a list of ready-made items to take their place selected. Only standard factory stock items were used.

How the Test Was Carried Out

The test was started on June 1, 1934, and on that date all current dressings were removed and, together with raw stocks on hand, stored in a locked space. All divisions of the hospital were then supplied with the manufactured types. Every effort was made to exercise close control over this material. It was housed in a separate storeroom, and one individual was engaged for the test period and held responsible for receipts, issuance and inventory. Because of this centralized control, it is believed that accurate and reliable consumption figures were obtained.

Dressings were issued only upon presentation of requisitions. These were tabulated weekly, showing the consumption for each department and computing balance on hand. A physical inventory of the stockroom was taken once each month. The inventory figures checked so closely with book entries that the factor of error from this source is negligible. At the close of the test period on August 31, 1934, the results of the experiment were summarized and tabulated.

In like manner a three months' experience using hospital-made dressings was tabulated. The time interval from June to August, 1931, was selected for this comparison because it most closely coincided with conditions of the test period, being in the same season of the year and having a similar number of hospital days. To eliminate variable factors further, the cost of dressings in the 1931 period was computed on the market price of raw material for 1934. This disposes of the variable price factor.

The tabulations cannot be reproduced here and it is not necessary that they should be, inasmuch as they constitute largely the work sheets leading up to the final conclusions. They were developed in great detail, showing the consumption of each type of dressing by each important division in the hospital, unit and total costs. This was done to make the analysis as complete as possible.

No operating room figures, either consumption or cost, were included in the comparison because in the operating room hospital-made dressings could not be entirely replaced by the ready-made type because of the demands of certain surgeons. This refers to the specialized types developed from time to time at the request of individuals. It was soon apparent that standardization of dressings would

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COST OF READY-MADE AND HOSPITAL-MADE DRESSINGS

	Medical			*Surgical*		
Type of Dressing	*Hospital Days (June-Aug. Inc.)*	*Total Cost of Dressings*	*Cost per Hospital Day*	*Hospital Days (June-Aug. Inc.)*	*Total Cost of Dressings*	*Cost per Hospital Day*
Hospital-made	17,043	$174.51	$0.0102	19,087	$1,570.62	$0.0820
Ready-made	14,137	160.04	0.0113	22,085	1,440.38	0.0650
Excess cost of ready-made	.....	.....	0.0011	.....	.....	.....
Excess cost of hospital-made	.....	.....	.....	.....	.....	0.0170

Computation of Net Saving

Saving on ready-made (surgical)—$0.0170 per hospital day for 22,085 days	$ 375.45
Less loss on ready-made (medical)—$0.0011 per day for 14,137 days	15.55
Net saving for three months	$ 359.90
Net saving for one year	$1,439.60

have to be undertaken before it would be possible to make a clear and accurate comparison of ready-made dressings with the customary type in that department. It is also reasonable to believe that conclusions arrived at with regard to other departments would indicate the trend in the operating rooms. In order not to cloud the picture by injecting a possibly noticeable factor of error, operating room dressing figures were omitted.

Tabular results show the total cost of dressings for all departments in the hospital except the operating rooms for the test period in 1934 amounted to $1,600.42 as opposed to $1,745.13 for the 1931 period. Before computing a unit cost, that is, a cost per hospital day, it is necessary to make further adjustments. In the 1934 period it was found that the number of surgical hospital days greatly exceeded those of 1931. Obviously this will have a definite influence since a larger percentage of dressings is used for surgical than for medical cases.

After investigating a number of test cases it was decided to group all patients into two divisions, surgical and medical. It was furthermore estimated that the former consumed 90 per cent of all dressings and the latter the remaining 10 per cent. Under surgical hospital days are included, in addition to all surgical cases, orthopedic and maternity cases (baby days are included in medical, mother days in surgical hospital days). It is admitted that this percentage is arbitrary and may be inaccurate, but since the calculations deal with fairly large multiples, only a small factor of error is injected.

Undoubtedly the types of surgical cases will vary and it is conceivable that there may be a preponderance of cases with much drainage in one three months' period as compared with another. This would introduce an error. Likewise, the number of minor surgical cases as against major, the number of children's surgical days as compared to adult surgical days, all must be considered as to their importance in introducing inaccuracies in the net result. It was found that in the two periods under consideration these variable factors did not account for any appreciable error.

In addition to the annual saving of $1,439.60 as shown in the table, there was a further tangible saving of paid work in the surgical supply room. It was estimated conservatively that twenty hours of time used in cutting and handling were eliminated, providing a saving of $312 a year. As this constitutes a fraction of one man, it is not certain that this gain could be realized.

There are a number of advantages which although they were definitely noticed, do not produce a tangible saving. Supplies can be more closely controlled as evidenced by experience during the test period. Time spent by student nurses on making special dressings can be eliminated, thus releasing them for more important work. And, as an additional advantage, ready-made dressings are uniform in size, shape and appearance, and completely eliminate all waste of material incidental to making dressings by hand.

Attention is directed to the fact that the unit costs established herein do not cover all items generally charged to dressings. They do not include operating room dressings, as noted above, brown and white cotton when not used in dressings, bandage rolls, adhesive tape, and possibly one or two items used in small quantities.

The above report undoubtedly contains inaccuracies both as to quantity and cost. It is believed, however, that these inaccuracies are small and do not greatly disturb the picture as a whole and that the conclusions are correct for all practical purposes. The final conclusions are as follows: Ready-made dressings are at least not more expensive than hospital-made dressings, even when 90 per cent of the labor used in making them is not chargeable. This experiment indicates, furthermore, that a saving of approximately 21 per cent was effected by the use of ready-made dressings.

MAINTENANCE, OPERATION AND EQUIPMENT

Simplifying the Laboratory Report

By STUART L. VAUGHAN, M.D.
Clinical Pathologist, Buffalo General Hospital, Buffalo, N. Y.

A PROBLEM of no small consequence is that pertaining to laboratory reports. To devise a system that will meet all needs is a difficult task involving much hard work and careful consideration of many factors. Cursory study will show that there are almost as many methods in use as there are hospitals. Some are relatively simple, while others are so complicated as to seem impracticable. Some are designed to meet the needs of one department with no regard for the needs of others. All are far from perfect.

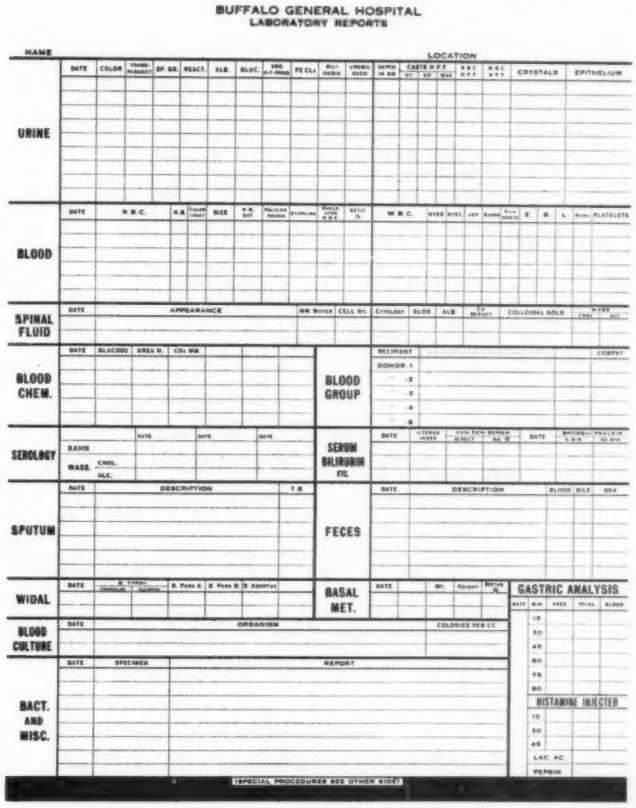
At Buffalo General Hospital we have used various systems and several times have attempted to improve upon one that has been tried and found wanting. Recently a rather painstaking study of the current situation resulted in a revision of our methods.

Radical Revision Was Necessary

The attack was roughly divided into several distinct steps. The first of these was an attempt to criticize the method being used. It must be admitted that we did not start exactly at scratch here, since generous critical comments had circulated through the hospital for some time. For twelve years a blanket chart, modified from time to time, had been in use. On the whole it had proved rather successful and most of the criticisms were directed toward minor details. It was obvious, however, that these criticisms covered such a number of details that revision must be of a radical nature.

As soon as this fact became evident, we decided that further steps should be taken in an orderly fashion. We proceeded therefore to define the purpose of laboratory reports from the standpoints of what they are supposed to accomplish and who are concerned in their use. It was clear at once that the results of laboratory procedures should be reported in such a way that they are readily available to those that need them. This means that any system devised must be acceptable to the clinical staff. At the same time it was recognized that other departments have a distinct interest in the matter. They are the laboratory staff, the hospital management and the librarian. It seemed logical then to consult each of these departments as to their needs and desires.

The clinical staff was consulted first. With few exceptions the members favored some type of blanket chart that would enable them to find a given report easily and that would show the results of various and repeated tests at a glance. Having become accustomed to the use of the blanket chart they preferred this to separate reports. It made the case record less bulky and there was less need to thumb through many pages to find what was



wanted. However, they demanded a chart that was well balanced, that showed sections clearly set off and properly grouped. Most of them wanted a chart that stood out from the others in the case record and was printed on one side of the page only.

The laboratory staff was interested naturally in economy in time of reporting and in ease of transcribing. Since much of the reporting was done by the technical workers it was obvious that they could not be too long away from the workroom. Furthermore, writing facilities at the bedside are not good. However, experience had shown that on a well constructed blanket chart a report usually requires the use of but a few words or figures and

the time involved is hardly greater than is required to transcribe reports in the laboratory and distribute them. On the whole the blanket form was favored.

The hospital management desired, other things being equal, to save printing and stationery costs. The use of one form to receive many reports has a decided economical advantage over many forms for separate reports. The librarian favored the blanket chart because the completed record was less bulky and required less filing space.

Since the various departments were agreed that the blanket form met the needs in our hospital best the next step was to collect exact data to guide us in the preparation of the chart. The collected criticisms of the older forms were a valuable nucleus. One important criticism, common to many blanket charts used elsewhere, was that the charts were too elaborate. An attempt had been made to include not only spaces for almost every conceivable report but also enough spaces to accommodate the needs of every type of patient. The result was not satisfactory for the special cases and made the form unhandy for the ordinary ones.

Many Case Records Analyzed

In order to gain a clearer insight into absolute needs it seemed logical to examine a series of completed case records. Several hundred of these were studied. They were taken consecutively as the patients were discharged, since this was essential to obtain proper distribution. From each record a tabulation was prepared of the procedures reported, together with the number of spaces used in reporting each procedure.

The results were interesting and somewhat surprising. Despite the large variety of tests performed in the laboratory it was found that but fourteen general types of tests occurred with sufficient frequency to warrant special space on a blanket chart. The remainder were found in less than 1 per cent of the records.

For these fourteen items the number of spaces required ranged from none to twenty-seven. It was clear that no single chart could be prepared to accommodate the needs in every case but our figures showed that in the vast majority of them the required spaces were relatively few. In fact when the maximum spatial requirements for each item in 95 per cent or more of the records were determined they were not great.

The accompanying table shows the results. The fourteen items are listed in order of their frequency of occurrence. Opposite them is the maximum number of spaces required in 95 per cent or more of the records.

While it seemed logical to prepare a chart that would accommodate all of the reports on such a high percentage of patients it was obvious that we should determine whether such a chart would be inconvenient in the remainder. This small group is important since it is made up largely of problem cases being intensively studied. Further scrutiny of our statistics showed that the use of one or more additional pages of the same chart would answer the difficulty in most instances.

STATISTICAL STUDY OF CONSECUTIVE CASE RECORDS

Item in Order of Frequency of Occurrence	*Maximum Number of Spaces Required in 95 Per Cent or More of the Records*
Urine	9
Blood count	6
Blood chemistry	5
Serologic diagnosis of syphilis	3
Bacteriology	8
Feces	6
Gastric analysis	1
Blood group	1
Sputum	6
Serum bilirubin	3
Spinal fluid	2
Basal metabolism	2
Widal	2
Blood culture	2

There was, however, the question of what to do with reports of procedures not included in the fourteen listed. Some of these special bacteriologic and hematologic reports, for example, tissue, are descriptive and require separate pages. Most of the others are short and can be placed in a space for miscellaneous reports.

And so, having decided that most of the facts were before us, the next step was to prepare the outline of our new chart. This was more time consuming than difficult. Special attention was paid to space economy, grouping and section headings. In each section the item headings and spaces were arranged to simplify reporting and reading.

As we have found in the past, it is essential that the printer cooperate fully in bringing out a finished product. A chart with as many rulings as ours is best printed from a special plate that is made over a wax impression. This in turn is made only with proper apparatus and skill. There must be proper accentuation of rulings to cause the sections to stand out clearly. We specified a paper size one-eighth inch longer than that of other pages in the case record and had a dark border printed at the bottom. The reverse side is ruled so that special reports may be placed there if desired. The accompanying chart shows the final result.

Soap Dispenser Tests

For the purpose of determining the relative advantages of various types of soap for washroom dispensers, tests were made in the men's washrooms on the first and second floors in Billings Hospital, University of Chicago Clinics. Three types of soap were used—liquid 33⅓ per cent solution, liquid 20 per cent solution and granulated soap. Each soap was used exclusively for a ten-day period in one of the washrooms. Results were as follows:

Washroom, first floor	*Amount*	*Cost*
Liquid soap—33⅓ per cent	36 oz.	$ .06
Granulated soap	18 oz.	.205
Washroom, second floor		
Liquid soap—33⅓ per cent	18 oz.	.03
Liquid soap—20 per cent	17 oz.	.02

Liquid soap was found to be superior to granulated soap. It was much less expensive to use and did not "mess up" the appearance of the washbasins as did the granulated soap.

Of the two liquid soaps, the 20 per cent soap was the less expensive to use. No more 20 per cent solution was used than 33⅓ per cent. This was not due to a drop in the volume of work being done. The total number of visits was actually higher during the period in which the 20 per cent solution was used. This substantiated the theory that regardless of the strength of the soap the number of punches a person gives a soap dispenser is guided by habit and not by the concentration of the soap. It was because of this fact that the granulated soap proved expensive. A large part of it was wasted.

A 20 per cent solution costs at least 30 per cent less to make than does the 33⅓ per cent solution. The annual cost of liquid soap in the clinics is about $200. A 30 per cent reduction of this cost represents a saving of about $60.

Bulk Ether and Hospital Fire Hazards

Since ether is more highly combustible than alcohol the general safeguard thrown about the storage and handling of alcohol should be provided in handling bulk ether. The general requirements for the storage of bulk ether therefore would be about as follows:

1. The drum should be stored and the ether should be drawn in a room cut off from the rest of the hospital by fire resistant partitions and a metal door and door frame. There is also a question whether it is desirable to store ether in large containers under any circumstances. In addition to the fire hazards there is the possibility of a serious explosion in case of the accumulation of a large amount of ether vapor.
2. The room should be well ventilated.
3. The electric wiring should be of the vaporproof type and lamps should be enclosed in vaporproof globes (a bare lamp bulb will ignite ether vapor).
4. Since ether vapor travels along the floor the door to the ether storage room should be airtight in order to prevent overnight seepage of the vapors along the floor line in case of leaks.

Even though the above precautions are taken there will probably be an added burden upon the hospital because of the increased insurance rate. As an illustration of this the Bureau of Combustibles reports the following schedule of increases in insurance rates applying to a certain state when bulk ether is stored:

	Fireproof Buildings	*Nonfireproof Buildings*	
1 quart	0	0	In approved safety containers only
Under 1 gallon	.04 per $100	.10 per $100	Charge is same regardless of type of container
1 to 5 gallons	.06 per $100	.15 per $100	
5 to 20 gallons	.10 per $100	.25 per $100	
Over 20 gallons	.20 per $100	.50 per $100	

These increased rates do not apply to the storage of ether in small hermetically sealed containers which do not permit ether vapor seepage.

The only true economy in hospital operation is the economy that results in a net money saving without jeopardy to the lives of patients, employees and staff. The savings in bulk ether for the average hospital will be more than offset by the cost of the expensive set-up, expensive storage provisions, cost of technician's time for daily analysis, the cost of ether wasted and the added cost of insurance.

To these definite costs should be added the insecurity of the hospital administrator who in case of accident will be compelled to defend in court the practice of handling in bulk containers a highly inflammable product such as ether.

The hospital's first obligation is to protect the lives and the interests of its patients. Economies are necessary but they must always be second in importance to the interest of the patient.

When Surgeons' Gowns Disintegrate

For several years the Davis Memorial Hospital, Elkins, W. Va., had been having difficulty with the disintegration of surgeons' gowns after sterilization. Much time and money were spent trying to remedy the condition, which was extremely expensive. Finally the hospital discovered the cause.

"We had been using for scrubbing up," writes Dr. Benjamin I. Golden, superintendent, "a solution known as Harrington's Solution. This is acid in nature. Thus where the gowns came in contact with the body, or where on removal they touched the acid moisture of the arms, they would disintegrate."

Protection for Painted Walls

A constant source of expense in hospitals both large and small is the cost of touching up and repainting walls that have become damaged by scraping chair backs.

This expense may be reduced to a minimum by placing plush bumper buttons on the backs of all chairs and other furniture that might bump these walls. In some cases rubber bumpers have been found useful for this purpose. These rubber bumpers do avoid damage to the walls from shock but they often leave a streak as the rubber bumper is dragged along the wall.

How to Buy Fresh Fruits and Vegetables

By MARY K. SORENSON

Chief Dietitian, Illinois Central Hospital, Chicago

In our November, 1934, issue Mrs. Gilbert's comprehensive article offered suggestions to the canned goods buyer. Now comes Miss Sorenson to tell those whose budget permits the year-round use of fresh vegetables how to buy them and use them to the best advantage

HOSPITAL dietitians and buyers of today are indeed fortunate in having such an abundant supply of fresh fruits and vegetables at their command the entire year.

In the past ten to fifteen years rapid progress has been made in production, marketing and transportation of these commodities. Production has increased and expanded to such an extent that it is now possible to buy fresh fruits and vegetables regardless of season and at a lower price than was possible a few years ago. Growers are improving the packing of their products to the extent of ensuring almost perfect condition of the goods as delivered. Better transportation facilities such as refrigerated cars and faster service of trains and trucks have done much to stimulate the opening of new producing areas and have brought the sections of the country into closer contact.

It is difficult to determine whether the increased supply of fruits and vegetables is the result of the demand for them or whether the increased supply created the demand. It is evident that the general public is becoming better educated as to the value of fresh fruits and vegetables in the diet. The discoverey of vitamins and their importance no doubt has been a stimulus to both supply and demand.

What the Buyer Should Consider

Some important factors to consider from the buyer's standpoint are location, type of hospital and budget allowance. Hospitals in or near the large producing areas have the advantage of buying direct and eliminating transportation cost and costs of packing. The amount of fresh fruits and vegetables purchased will vary with the season of the year, the abundance of the crops and the type of hospital. However, it is safe to say that from 8 to 12 per cent of the budget is spent for fresh fruits and vegetables. This allows for rather generous use throughout the year. The tendency is growing toward a greater use of fresh fruits and vegetables especially in private hospitals where cost is not the chief factor. With a better supply and greater variety assured at reasonable costs, rather extensive use is justifiable. Should one particular item be scarce and the price high, other items within a better cost range can be used as there is sufficient variety from which to choose.

To obtain the best results and buy to the best advantage a rather extensive knowledge of fresh fruits and vegetables is necessary. A background of knowledge of the many producing regions, their seasonal products, growing, harvesting, grading, packing and transporting makes the task of buying these commodities easier as well as much more interesting.

Much advancement has been made in the production of fresh fruits and vegetables. Many new areas have been developed particularly in the Southwest and on the Pacific Coast. The irrigated regions of the Rio Grande Valley and the rich soil of the gulf region have ideal growing conditions for unlimited production. Texas and Arizona are seriously competing with Florida in citrus fruit production, as their crops are marketed at the same time. Oranges and grapefruit from this section are of a practically seedless variety and are some-

what sweeter than Florida fruit. Truck farming has reached the point of large scale production in Texas and surrounding states. Garden vegetables are shipped north and east for winter use with a slight advantage over California in cheaper shipping costs. California and Pacific Coast states are also heavy producers of winter garden vegetables, and regardless of higher shipping costs are becoming firmly established in Middle Western and Eastern markets.

Sharply defined seasons are gradually disappearing as the various growing regions dovetail their products. Ten or twelve years ago Northern and Eastern supply houses were forced to store root vegetables such as beets, carrots, turnips and cabbage for midwinter and early spring consumption. Southern and Pacific Coast products now appear in sufficient amounts to sell at a nominal cost. However, this past season crops were damaged by frosts and the costs were considerably higher. Root vegetables from these regions make a better serving vegetable as they are of more uniform size, are less starchy and have a better appearance. Garden vegetables such as green beans, peas, spinach, cauliflower and tomatoes are produced in these newer growing regions as soon as the northern crops are exhausted, so there is no time that they are not offered in the markets.

Much advancement has been made in such staple articles as lettuce and potatoes. Lettuce growing is confined almost entirely to the west coast. The cooler regions of California, Arizona, Oregon, Washington and Colorado are able to offer a continued crop except perhaps during July. The iceberg type of lettuce from these regions dominates the market. Florida ships some Big Boston in winter and leaf lettuce appears in the local markets in summer.

Storage potatoes from the northern states are showing much improvement in quality. Colorado and other mountain states are now producing an excellent white potato with a red skin called the McClure. It has the advantage over the Northern potato in that it does not discolor when boiled, however, the price is considerably higher than that of Michigan and Wisconsin potatoes. The Idaho russet potato from this state and surrounding irrigated regions is now taken for granted as an unsurpassed baking potato. Cost of shipping has failed to discourage its use. Sweet potatoes are no longer disappearing from the markets for two or three months of the year. By a dry kiln method sweet potatoes are kept at a temperature of 70-80° F. for two to three days and then the temperature is dropped. In this manner the pores are closed and keeping qualities much improved.

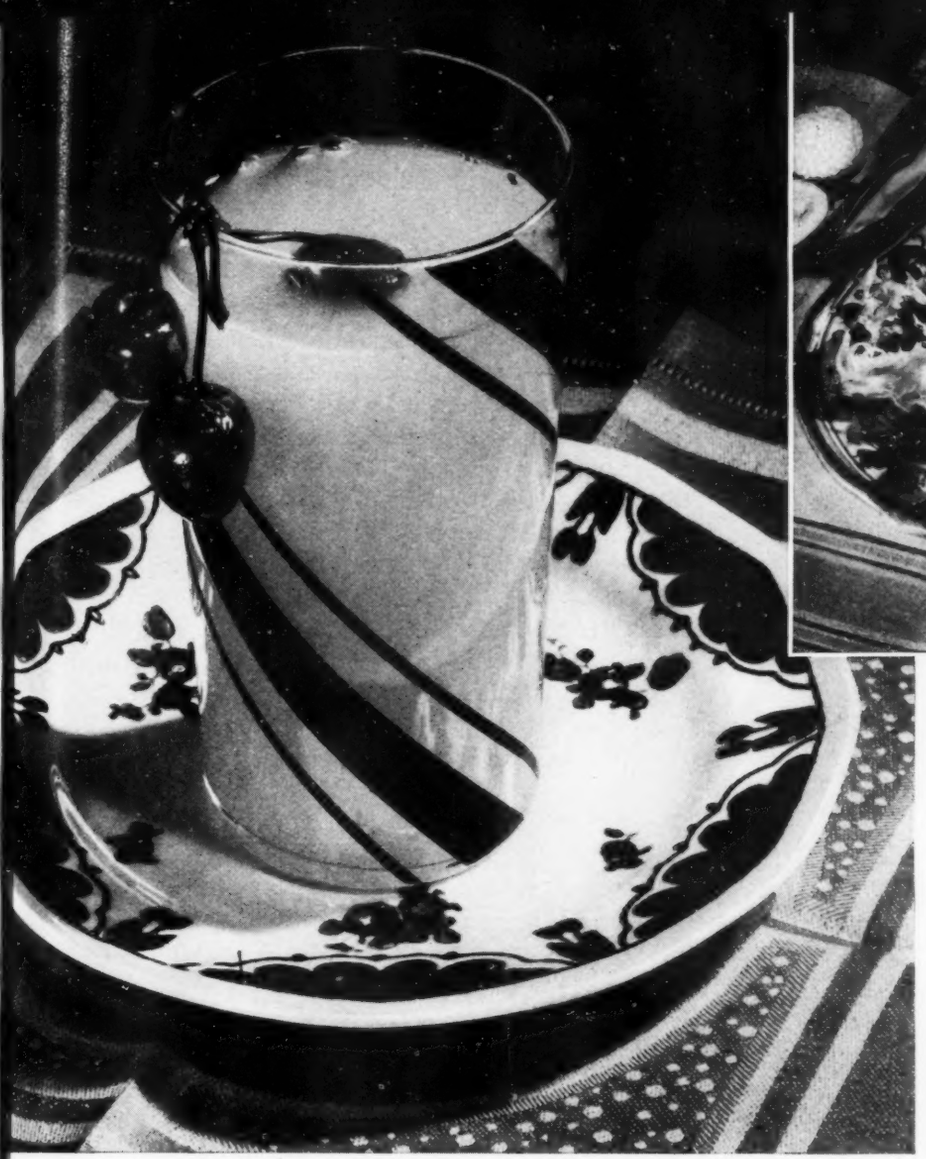
It is interesting to note that greenhouse cultivation of cucumbers, radishes, tomatoes and endives is becoming common. Ohio and other central states in the soft coal regions are concentrating on greenhouse culture. Mushroom culture is also increasing, particularly near large cities. Mushrooms are offered in the markets at a cost which does not prohibit occasional use.

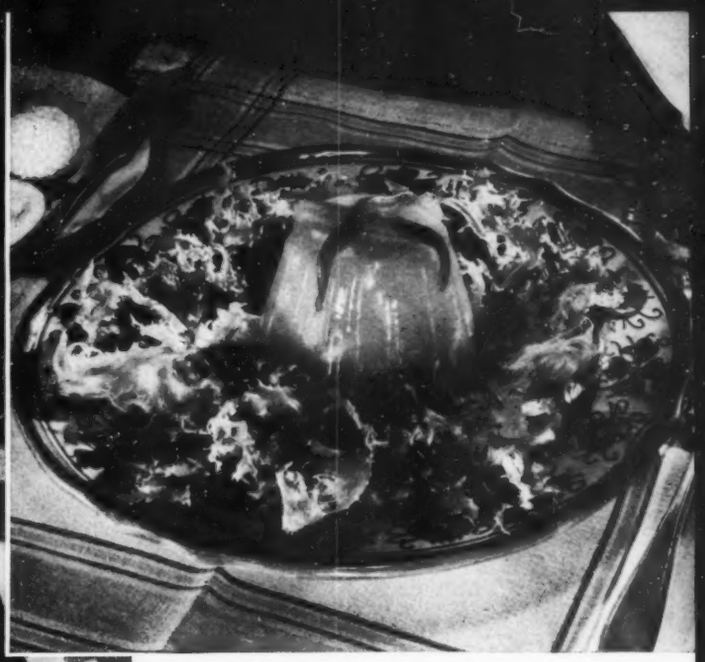
Some of the newer fruits and vegetables being produced in large enough quantities so that they only border on the luxury class are asparagus, Brussels sprouts, broccoli, canteloupes, strawberries and avocado pears. Brussels sprouts and avocado pears are strictly California products. Arizona and California are shipping canteloupes in greater quantities and they are arriving in good condition. Precooled canteloupes, those that are cooled immediately after picking, are being featured extensively as they arrive in better condition than those packed in the ordinary way. Strawberry growing has increased considerably in the past few years. Southern berries appear on the markets early in January and crops follow in succession from Florida, Louisiana, Mississippi, Tennessee and Ken-

THE YIELD IN FRESH VEGETABLES

Vegetable	*Prep. Waste Per Cent*	*Usable Per Cent*	*Cooking Loss Per Cent*	*Cooking Gain Per Cent*	*2-oz. Servings per lb. A. P.*	*2-oz. Servings per lb. P. N.*	*Lbs. to Yield 100—2-oz. Serv. A. P.*	*Lbs. to Yield 100—2-oz. Serv. P. N.*
Asparagus	40.11	59.74	3.93	.....	4.59	7.69	22.51	13.00
Beans, Snap	9.76	90.24	3.14	.....	7.06	7.71	14.19	12.71
Beets	22.93	77.09	11.90	.....	5.35	6.92	18.88	14.06
Broccoli	46.07	53.92	4.31	.....	3.96	7.58	25.34	13.20
Cabbage	26.01	73.97	2.97	.....	5.54	7.87	18.40	14.80
Carrots	21.69	78.31	13.94	.....	5.15	6.82	20.09	14.91
Cauliflower	38.79	61.58	3.95	.....	4.35	7.71	24.56	12.97
Peas	60.22	40.24	1.69	.....	3.23	7.91	33.17	12.65
Potatoes, Sweet	36.19	63.81	1.15	.....	4.98	7.89	20.34	12.68
Spinach	19.94	80.06	21.87	.....	5.02	6.28	20.23	15.66
Squash, Hubbard	33.08	66.92	11.94	.....	4.70	7.05	21.29	13.28
Squash, Summer	12.91	87.09	12.35	.....	5.89	6.60	18.82	15.55
Turnips, White	17.79	82.21	5.47	.....	6.24	7.45	16.02	13.43

A. P. = as purchased.
P. N. = prepared net.
Study made by A. D. A., 1932-33.





● FOR THE LAXATIVE DIET Gelatin molds, made with Libby's Hawaiian Pineapple Juice, diced cucumber and celery, are wonderfully attractive. Serve on chicory or lettuce with mayonnaise.

● ESPECIALLY FOR BREAKFAST patients and staff will welcome this delicious change. Libby's Pineapple Juice is unsweetened, tangy. It has the nutritional values you look for in a fruit juice; a refreshing drink for patients with fevers and sore throats; may be used in diabetic diets.

Libby's 100 Fine Foods include Fruits and Fruit Juices, Vegetables, Pickles, Condiments, Canned Meats, Evaporated Milk, Alaska Salmon. Each comes in regular and special sizes for institutions. In addition Libby packs Homogenized Foods for Babies.

NOW...GIVE THEM THEIR VITAMINS IN A *FRUIT JUICE DELICIOUSLY DIFFERENT!*

LIBBY'S UNSWEETENED PINEAPPLE JUICE...RICH IN ESTERS

Patients, and members of the staff as well, will be enthusiastic about this new and different fruit juice. Especially for breakfast, Libby's Hawaiian Pineapple Juice is a glorious flavor change.

Libby's is the natural juice of field-ripened Hawaiian pineapple . . . *unsweetened*. Rich in Esters, the flavor-carriers of the full-ripe fruit, it tastes exceptionally delicious.

Libby's Pineapple Juice is a good source of Vitamins A, B and C; it also supplies alkali-forming minerals and other nutritional essentials. And these values are uniform the year around.

You can get this fine Pineapple Juice of Libby's from your usual source of supply. It costs you no more than ordinary brands. Libby, McNeill & Libby, Dept. N-55, Welfare Bldg., Chicago.

ACCEPTED BY THE A. M. A. Libby's Hawaiian Pineapple Juice bears the Seal of Acceptance of the Committee on Foods of the A. M. A.

● FOR THE BLAND DIET—an unusually delectable Bavarian Cream, made with lemon-flavored gelatin and Libby's Pineapple Juice.

tucky, finally meeting the northern local crops in June.

Added to the need for a comprehensive background of production knowledge is a familiarity with marketing methods as a further aid in better buying. Marketing methods include harvesting, grading, packing and shipping. Both fruits and vegetables are packed at a central point at or near the growing point. Goods are packed according to weight, size or count, and graded as to extra fancy, fancy choice, standards and substandards. Various types of containers are used but growers are gradually standardizing all containers for more uniform weights and counts. At the present time citrus fruits are well standardized both as to count and quality. There is still some variation in package weights of spinach, tomatoes, celery, strawberries and other small fruits.

The potatoes are the only commodity subject to government regulation. They are mechanically graded as U. S. No. 1 and U. S. No. 2. As to quality they must be mature, sound, free from damage by insects or injury. The weight is standardized at 100 pounds to the bag. However, new potatoes are shipped in 50-pound boxes or 50-pound bags. The apple industry on the west coast conforms to government recommendations as to quality.

Growers have set high standards among themselves as to quality and perfection of packs. Some growers are featuring their products under their own trade brand and are advertising quite extensively. This always tends to uphold standards. Refrigeration has been a strong factor in improving the fruit and vegetable industry. Without refrigerated cars, it would be impossible to ship perishables across the country in good condition. Many vegetables are now also iced when packed to ensure a fresher condition of the delivered product.

It is now evident that many factors influence the ultimate cost of fresh fruits and vegetables and definite buying standards should be formulated. The cost per serving is the logical foundation for a working basis. The net yield of a given package is the factor which determines the per serving cost. There is always considerable variation in the net yield of both fruits and vegetables, therefore a bargain is only a bargain when the net yield is standard or above standard. The accompanying table shows a study made of fresh vegetable yield which shows how a cost per serving chart can be developed. A similar chart showing the comparative cost of fresh vegetables with canned and frozen would be of great help in buying. The cost of labor is a factor which must not be ignored in making these comparisons.

The ideal method of buying is personal selection of commodities. However, this must be fortified with definite specifications as to quality, size, count or weight desired. Price comparison and purchasing from reliable dealers are essential. Reliable dealers are in a position to make good any losses that might occur. Care should be taken at time of delivery to see that the goods received check with the given specifications. If they do not, the dealer should be notified.

No. 11—Mother's Day Salad

By Arnold Shircliffe*

Lettuce
Grapefruit
Cream Cheese
Green Pepper
Rubyettes

ON A BASE of lettuce or slice of lettuce, pipe a letter M with cream cheese. On top of the M place four sections of grapefruit which have been cut through the center but not entirely severed. Fill slits of grapefruit with cream cheese and place thin strips of green peppers on top of cheese forming the letter M. At top of points and at the bottom center place hearts cut from a pimento and arrange halved red cherries or rubyettes along center strips of pepper. Serve with Lorenzo Dressing.

*Author of the Edgewater Beach Salad Book.

New Quarters for Old

By ESTHER M. RHODES
Dietitian, Genesee Hospital, Rochester, N. Y.

EVERY dietitian enjoys new quarters after she is safely established in them; it is the long stretch while they are being built that is beset with difficulties.

Our reasons for building at this time were to give work to people at a time when employment was scarce and the boards furnishing building funds would never forgive waiting until materials were out of sight in price.

Our first building problem was one of location. A first floor workroom would be light, airy and comparatively free from the possibility of vermin and insects. On the other hand the ground floor could be well ventilated, made light and with care could be kept free from roaches and vermin. It would also simplify the delivery of supplies and keep the noise and odor accompanying the preparation of food from the patients. As all food is transported in electrically heated food trucks at our hospital, the additional distance made by one floor in the conveyance of prepared food did not really matter. You may easily see why the ground floor became the final site.

In the new kitchen the problem of air is taken care of by a large exhaust fan housed on the roof of the building. It is securely anchored to the floor and heavily insulated to break any vibration. There are exhaust ducts leading to the fan from the nurses' cafeteria, the dishwashing room, the diet kitchen and the main kitchen.

Kitchen Is Soundproofed

Daylight is admitted by long windows on the east and west and a skylight over the central part of the kitchen. The walls are of cream colored tile and the ceiling is soundproofed and white.

The soundproofing not only protects the outsiders from noise which heretofore radiated to them but keeps the kitchen more quiet and less nerve racking for the workers. There is no noise in the kitchen from the exhaust fan as it is housed outside and the soundproofed ceiling absorbs noise within the kitchen.

The arrangement of the kitchen may have something to do with the noise lessening. Our kitchen is divided by its equipment into spaces for salad preparation, vegetable preparation, pastry work and vegetable and meat cookery. This means that each person practically has his own corner and works in it, with less chance of conversation than when all are working in one group. Employees do not seem to be inclined to shout back and forth in this large kitchen as they did in the smaller one.

It is advisable to make a good many expeditions to other well equipped places before deciding on equipment and arrangements, but every situation is an individual one and your final decision must be guided by a consideration of all sides of your own problem.

Equipment Should Be Carefully Installed

Equipment should be regulated for height. Sinks and tables must be at heights that will not break the backs of your employees. If when sinks, tables and other pieces of equipment are installed spaces are left, either have them filled so that dirt cannot get into the cracks or make the spaces large enough to be accessible for cleaning. Watch the corners of your tables and other metal work for smooth connections or soon there will be trouble with cuts and bruises as well as torn aprons and uniforms.

In arranging equipment the workers' convenience as well as the sources of supply and demand must be considered. When we plan for the salad room, we must have a sink for washing lettuce, a refrigerator to store the finished product, and a table on which to prepare salads. These should be near the place at which you wish to dispense salads. If you have only one mixing machine it should be placed near both the baker and the meat and vegetable cookery. Buy your equipment to fit your space.

Drains in the floors are necessary, but not much use if the floor does not slope toward them. There should be enough drains so that the whole kitchen does not have to be cleaned when one steam kettle has been emptied.

If there is a fruit and vegetable cooler and one for meat and one for butter and milk, then these articles of food can be kept at their best temperatures without danger of taint, freezing or under cooling. If your refrigerator space is ample you can buy larger cuts of meat or do other large quantity buying and have a place to store a surplus. This way buying expenses may be cut down as well as time saved in ordering and reordering.

See that switches are conveniently placed, for no one ever goes out of his way to turn out a light. Switches should be outside of refrigerator doors, and it is advisable to have a red bulb indicator to show when the light is on. Lights themselves should be situated to give the most light without shining in the worker's eyes or casting a shadow on his work. Legs of tables should be round so that dirt cannot find a lodging place and corners of the room should be rounded for the same reason. Tile floors are easy to keep clean, they wear well and look nice. On the other hand, they are slippery when wet.

It might be well to mention adjustments we found had to be made during building. The stability and humor of your staff are vitally important. Good employees rise to the situation and help you through any difficulties. People who have worked with equipment generally figure out the best arrangements, as their work cannot be speedy unless their equipment is conveniently located, and for this reason your employees should work with you on ideas for the building plans. They will probably be eager to see what their new working conditions will be like.

There were long weeks of inconvenience during which food had to be covered and carried from building to building. When we did move into the new building, the menu had to be planned so that no steam was used on one day and no gas another day. In all this there had to be cooperation with other departments and the alterations had to be made at a time agreeable to all concerned. Your old equipment should be cleaned and resurfaced before it is moved. This work, of course, has to be scheduled so that you are not crippled too much in your necessary daily food preparations.

I want to mention a few things that a dietitian must have in mind when her department is being built or remodeled. Above all, don't worry about the work. Do not get "edgy" or lose your sense of humor. You must be ready to meet those who will not like the color of the paint, or the site, or the arrangement, or the noise of construction, or the inconvenience of extra steps.

It is wise to know something about brands of equipment, and durability and suitability of materials used, but your real safety depends upon the honesty and reliability of contractors, architects and equipment people. The test of how well the job has been done comes only when the new quarters and new equipment are put into service and you must be prepared to make many adjustments until the arrangements work smoothly.

Reducing Electric Fuel Costs in the Kitchen

There are a few simple rules which if obeyed implicitly by cooks and chefs will reduce electric fuel costs in the kitchen, says J. M. Welch, writing in *Hotel Management*. His rules for economically operating the electric kitchen follow:

1. Use automatic temperature controls wherever possible. Many a pan of good food has gone into the garbage can because the cook "forgot" for a moment and many a meter has ticked off dollars of expense because of carelessness. The machine does not forget nor is it careless with money.

2. Use specialized equipment. Many kitchens are still attempting to use for all types of cooking a general purpose device—the range—with its long stretch of heated surface so seldom completely covered with pots and pans, radiating heat to the kitchen air. It costs money to produce this wasted heat and it costs money in ventilation to remove it.

3. Secure the lowest cost possible per kilowatt hour of electric current by using all the electrically operated equipment most efficiently. In the kitchen this is accomplished by a schedule of turning on and heating up equipment as it is needed.

4. Use no more heat than is necessary. A cooking operation cannot be speeded by having a pot boiling violently or grease in the pan sputtering and smoking. Water, for example, never exceeds 212° F. no matter how violently it boils.

5. Train the operating personnel to proper habits in equipment operation. Two habits which will result in definite fuel saving are: (a) the habit of turning switches to "low" or "off" when a device is idle or when a pot is boiling; (b) the habit of utilizing stored heat in equipment.

6. Keep all equipment clean. Nothing damages equipment so quickly as grease, dirt and filth.

Cold Storage of Vegetables

Many dietitians have wondered why vegetables would not keep in cold storage. According to a Cornell University bulletin, vegetables may lose quality in cold storage from any one of three causes: chemical changes, wilting or spread of storage diseases.

After three years' study on cold storage of vegetables, Cornell scientists recommend certain temperatures at which certain vegetables will keep longest. The Fahrenheit scale is used, followed by the maximum storage period recommended:

Asparagus, 32 degrees, one week; lima beans, 32 degrees, two to three weeks; beets, 32 to 40 degrees, four to five months; cabbage, 32 to 40 degrees, five months; carrots, 32 to 40 degrees, six months; cauliflower, 32 degrees, thirty to forty days; celery, 32 degrees, three to five months; cucumbers, 32 to 40 degrees, four to five weeks; lettuce, 32 degrees, three to four weeks; onions and onion sets, 31 to 32 degrees, five months; green peas, 32 degrees, two weeks; parsnips, 32 degrees, five months; squash, 40 degrees, five months; sweet corn, 32 degrees, three to four weeks; green tomatoes, 50 to 60 degrees, one month, and ripe tomatoes, 40 degrees, ten days.

GELATINE *for Tempting Easily Digested Dishes at*

HENROTIN HOSPITAL CHICAGO

Miss Blanche Joseph, chief of dietetics at Henrotin Hospital in Chicago, says: "No matter what other foods are given, the body always needs protein for the replacement of waste and the building of new tissue. For the sick and convalescent here we often arrange to have the protein in the form of gelatine because it lends itself to a wide variety of palatable dishes and makes it easy for patients to get protein's metabolism-stimulating effects."

HERE IS ONE OF MISS JOSEPH'S FAVORITE RECIPES

Rose Apples in Mint Jelly (50 servings)

2/3 Cup Knox Gelatine
3 Cups Cold Water
6 Cups Hot Water
Green Coloring
3 Cans Rose Apples
2 Heads Cabbage, finely shredded
2 Cups Sugar
1 Cup Lemon Juice
8 Tablespoonfuls Spearmint Flavoring
1 Teaspoonful Salt

Pour cold water in bowl and sprinkle gelatine on top of water. Add sugar, salt and hot water and stir until dissolved. Add green coloring, lemon juice and flavoring. Cool. Drain Rose Apples and stuff with finely shredded cabbage. Mold in individual molds. Serve on chicory with mayonnaise.

THERE IS NO FINER GELATINE

for the diet of the sick than Knox Gelatine. It is purer than U.S.P. requirements and is free of pathogenic, gas, or acid-forming bacteria. As carefully made and supervised as an ampule solution. Gelatine may be used freely in the diet of convalescent, post-operative, tubercular, and chronically ill patients, because it is one of the most easily assimilated forms of protein. Patients appreciate the variety it adds to the regular hospital regimen.

PREFERRED BY HOSPITAL AUTHORITIES

KNOX SPARKLING GELATINE

Also manufacturers of Knox Jell (flavored) for Institutions

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KNOX GELATINE LABORATORIES, 465 Knox Avenue, Johnstown, N. Y.
Please send me FREE your booklets, "Feeding Sick Patients," "Feeding Diabetic Patients" and "Reducing Diets."

Name.....

Address.....

City..... *State*.....

June Breakfast and Supper Menus*

By NELDA ROSS

Director, Nutrition Department, Presbyterian Hospital, New York City

	BREAKFAST		SUPPER				
Day	*Fruit*	*Main Dish*	*Appetizer or Soup*	*Main Dish*	*Potatoes or Substitute*	*Vegetable or Salad*	*Dessert*
1.	Grapefruit	Fried Eggs	New England Clam Chowder	Swiss Cheese and Peanut Butter Sandwiches		Apple and Grape Salad, Cream Mayonnaise	Pineapple Tapioca
2.	Applesauce	Scrambled Eggs	Tomato Juice	Veal Fricassee	Boiled Rice	Lettuce, French Dressing	Prune Upside Down Cake
3.	Orange Juice	Broiled Ham	Canadian Cheese Soup	Stuffed Eggs	Potato Salad With Sliced Tomato		Apricot Cream Pie
4.	Prunes	Soft Cooked Eggs	Barley Broth	Crisp Bacon	Escalloped Kernels of Corn	Cabbage and Green Pepper Salad	Stewed Pears, Caramel Cookies
5.	Tomato Juice	Scrambled Eggs With Chopped Sausage	Cream of Pea Soup	Cream Cheese and Celery Sandwiches		Fresh Fruit Salad	Devil's Food Cake, Silhouette Frosting
6.	Banana	Bacon and Eggs	Potato-Leek Soup	Noodles With Ground Meat, Tomato Sauce		Mixed Green Salad	Baked Apple
7.	Stewed Pears	Baked Eggs	Rice Broth	Buttered Asparagus	Cheese Biscuit	Lettuce and Tomato Salad	Baked Coconut Custard
8.	Orange	Fried Eggs	Vegetable Soup	Salmon Casserole		Lettuce, Thousand Island Dressing	Frosted Spice Cake
9.	Fresh Pineapple	Poached Eggs	Corn Chowder	Small Sausages, Apple Ring	Baked Sweet Potatoes	Celery Hearts	Strawberry Whip, Custard Sauce
10.	Apple	Bacon	Cream of Lima Bean Soup	Cottage Cheese, Green Pepper	Potato Chips	Lettuce and Tomato	Deep Dish Blackberry Pie
11.	Apricots	Soft Cooked Eggs	Grapefruit (½)	Veal Sauté, Sherry Sauce	Creamed Macaroni	Green Salad, Chiffonade Dressing	Crumb Cake
12.	Rhubarb	Bacon	Consommé Royale	Rice and Minced Chicken, Gravy	Glazed Carrots	Lettuce and Orange Salad	Vanilla Blancmange, Fruit Sauce
13.	Orange	Puffy Omelet	Cream of Tomato Soup	Crisp Bacon	Cauliflower, Cheese Sauce	Banana and Nut Salad	Blueberry Muffins
14.	Fresh Pineapple	Sausages	Cream of Celery Soup	Baked Egg in Whole Tomato	Creamed Potatoes	Cabbage Salad	Orange Cake Roll
15.	Stewed Pears	Fried Eggs	Noodle Broth	Baked Cheese Pudding		Lettuce, Watermelon Pickle Dressing	Sliced Peaches, Brownie
16.	Tomato Juice	Scrambled Eggs	Cream of Spinach Soup	Hamburg Patty	Buttered Corn	Radishes and Pickles	Jellied Banana
17.	Melon	Canadian Bacon	Purée of Pea Soup	Sardine and Egg Salad	Sweet Potato Puff		Stewed Pears, Marguerites
18.	Prunes	Soft Cooked Eggs	Jellied Broth	Baked Stuffed Pepper	Pickled Beets	Waldorf Salad	Coconut Buns
19.	Orange	Scrambled Eggs With Ground Ham	Scotch Broth	Vegetable Plate: Baked Potato, Julienne Carrots, Asparagus		Celery Hearts	Cream Cheese, Jelly and Saltines
20.	Applesauce	Fried Eggs	Potage Mongole	Cold Salmon, Cucumber Sauce	Escalloped Potatoes	Lettuce	Date Tapioca
21.	Melon	Poached Eggs	Vegetable Soup	Ham Balls	Creamed Cabbage	Spiced Apricots	Fresh Pineapple, Cookies
22.	Tomato Juice	Eggs or Sausages	Oxtail Soup	Omelet, Creamed Mushrooms	Roll	Lettuce, Sweet Pickle Dressing	Cherry Upside Down Cake, Cherry Sauce
23.	Stewed Pears	Soft Cooked Eggs	Black Bean Soup	Italian Spaghetti		Coleslaw	Fresh Mixed Fruit
24.	Strawberries	Bacon and Eggs	Tomato Juice	Cold Sliced Meat Loaf	Creamed New Potatoes and Peas	Lettuce, Roquefort Cheese Dressing	Apple Dumpling
25.	Apricots	Jelly Omelet	Cream of Lima Bean Soup	Welsh Rabbit on Saltines	Grilled Tomato	Fresh Fruit Salad	Gingerbread
26.	Banana	Soft Cooked Eggs	Cream of Asparagus Soup	Frizzled Ham	Baked Lima Beans	Cucumber Salad	Rhubarb, Frosted Cookies
27.	Stewed Plums	Bacon	Jellied Tomato Broth	Poached Eggs on Spinach		Banana Salad	Nut Cake, Coconut Frosting
28.	Orange	Fried Eggs	Melon Balls	Creamed Chicken With Biscuit		Tomato and Lettuce Salad	Fresh Pineapple and Strawberries
29.	Fresh Pineapple	Bacon or Eggs	Cream of Vegetable Soup	Egg Salad Sandwich	Baked String Beans With Bacon	Radishes	Chocolate Cream Pie
30.	Apple	Sausages	Tomato Juice	Cold Sliced Meat	Celery Sticks, Fried	Potato Salad	Stewed Cherries, Cookies

*Cereals, breads and beverages are omitted from the breakfast menus because of space limitations. Recipes for any of the foregoing dishes will be supplied on request by Anna E. Boller, Central Free Dispensary, Rush Medical College, Chicago.

NEWS OF THE MONTH

Monsignor Griffin Attacks Hopkins' Stand on Federal Aid for Hospitals

An intimation that the joint committee of the three national hospital associations might continue to seek federal funds for the care of relief patients in hospitals was made by Monsignor Maurice F. Griffin, Cleveland, in addressing the record breaking meeting of the Ohio Hospital Association held in Columbus on April 2, 3 and 4.

The attitude of Harry L. Hopkins, federal relief administrator, toward the requests of the hospitals has been high-handed and arbitrary, Rev. Mr. Griffin declared. Mr. Hopkins based his first refusal of aid to hospitals on the grounds that the hospitals had not helped to lobby for the relief appropriation. When the hospitals offered to appear before congressional committees to present their case when the second appropriation was being considered Mr. Hopkins double-crossed them, Rev. Mr. Griffin declared, by failing to notify them of the hearing and himself presenting the case of the hospitals in so distorted a light that any congressional committee would refuse it. Rev. Mr. Griffin took occasion to contrast the attitude of Mr. Hopkins with that of other Washington officials.

Joint Meeting With Allied Groups

Nearly 300 persons registered for the meeting of the Ohio Hospital Association. In addition there were many in attendance at the meetings of the Ohio Dietetic Association, the Ohio Association of Record Librarians, the Ohio Association of Nurse Anesthetists and the Hospital Obstetric Society of Ohio. The hospital association held a joint meeting with each of the related groups. An exhibit of hospital supplies and equipment also featured the convention, the first exhibit the association has had for ten years.

The retiring president of the association, John R. Mannix, assistant administrator, University Hospitals, Cleveland, presented a series of objectives toward which the association should work in the future. These included the licensing of all hospitals, legislation to make it mandatory upon counties to pay for hospital care of the indigent, statewide group hospitalization, continued cooperation with state officials, central purchasing and collection for the hospitals of the state and uniform hospital accounting following the new A. H. A. manual.

Association's Aims

Other suggested objectives were: a uniform hospital report to all state departments and national organizations now requiring reports from Ohio hospitals, uniform practice regarding insurance for hospitals, a standard formula for determining hospital rates and charges and the elimination of special charges, a uniform formula for determining charges to governmental and insurance agencies, a study of hospital salaries, continuation of the study of the relations of governmental and voluntary hospitals, further study of nursing education and of the relations to physicians, especially as regards x-ray and laboratory work, adoption of the new standard classified nomenclature of diseases by all hospitals, a study of unit costs of hospital supplies and equipment, a statewide public education program for Ohio hospitals and the financing of a full-time executive secretary.

The report of the committee on state legislative relations, presented by B. W. Stewart, Youngstown Hospitals, Youngstown, chairman of the committee, showed an exceedingly successful year. Almost the entire legislative program asked by Ohio hospitals was enacted and no important bill inimical to hospitals was passed. The auto accident compensation bill, under which the state highway department pays for the hospital care of any person injured on a highway when the hospital cannot otherwise collect, was made permanent without the loss of a single day's protection to hospitals. Two bills were required to do this.

The work of the state relations committee under the leadership of Mr. Stewart has not only saved the hospitals of Ohio a great deal of money in the form of exemptions from sales and other taxes but it has also created a cooperative spirit between the hospitals and the state officials. At the annual banquet Governor Martin L. Davey made the address of welcome and some fifteen or twenty officials of various state departments were guests of the association.

John A. McNamara, director, Cleveland Hospital Service Association, presented a plan for statewide group hospitalization using the Cleveland plan as a model. He declared that the Cleveland experience would save a great deal of money for other cities who could use the same forms, contracts, accounting system and administrative direction. It would also make possible enrollment of employees of statewide corporations. The plan was referred to the trustees for study and action.

A. H. A. Officials Present

Both Robert Jolly, president of the A. H. A., and Dr. R. C. Buerki, president-elect, conducted round tables, the former on administrative problems and the latter on professional problems.

The methods of controlling maternal mortality were thoroughly explored in a joint meeting with the Hospital Obstetric Society of Ohio. A series of standards proposed by the society were presented by Dr. Walter Brand, Toledo. These are harmonious with the standards proposed in the manual soon to be published by the council on community relations and administrative practice of the American Hospital Association.

At the concluding business session the hospitals voted to continue to send 5 per cent of their receipts under the auto accident compensation law to the state association to support its legislative and other activities and to recommend to all member hospitals that only recognized physicians be permitted to practice therein.

Dr. M. F. Steele, superintendent, Grant Hospital, Columbus, was installed as president and Guy J. Clark, secretary, Cleveland Hospital Council, was chosen president-elect.

Nursing Schools Close

Seventy-four accredited schools of nursing closed during 1934, according to the National League of Nursing Education, and among the 1,509 still operating are several that are considering closing this year.

First Survey of Canada's Hospitals Made Public by Bureau of Statistics

The first statistical survey of the work of Canadian hospitals on a dominionwide basis has just been made public by the Dominion Bureau of Statistics. The report applies to the year 1932.

Canada has 860 hospitals, excluding mental and incurable, with 51,577 beds. They represent a capital investment of $152,389,373. Nearly $38,000,000 was spent in 1932 for the maintenance of these hospitals. They had an occupancy of 64 per cent. There were 588,761 admissions, 67,294 live births, 2,888 still births and a total number of persons receiving treatment of 622,069. Over 12,000,000 patient days of service were furnished to adults and children and 905,000 to newborn infants. On an average there were 1.3 days of hospital care provided for every man, woman and child in Canada. Of the 12,000,000 patient days over 2,500,000 were for indigent patients. The average length of stay of patients was 19.3 days.

X-ray facilities were found in 482 hospitals, clinical laboratories in 349, physical therapy departments in 215 and out-patient departments in 216. Over 710,000 patients were treated in out-patient departments.

Doctors attending patients during the year numbered 11,416, salaried physicians on hospital staffs, 726, interns, 733, graduate nurses, 5,210, student nurses, 9,472, and all other employees, 16,349, giving a rough average of three employees per five hospital beds or one employee per patient in these institutions.

The average cost per patient day for the public hospitals was $2.87, for the private hospitals, $3.22, for the dominion hospitals, $2.73, and for the hospitals for the incurable patients, $1.30.

John Howard, Jr., to Fill Marie Louis' Post

John Howard, Jr., has been appointed acting superintendent at Muhlenberg Hospital, Plainfield, N. J., to succeed Marie Louis who died March 28 after a brief attack of pneumonia.

The death of Miss Louis, head of Muhlenberg Hospital since 1920 and prominent for many years in the nursing and hospital fields, came as a great shock to her many friends and professional associates who were not even aware of her illness.

Born in Berne, Switzerland, Miss Louis came to this country in her early youth and trained as a nurse at Bellevue Hospital in New York. After graduating, she served for five years at Long Island College Hospital, Brooklyn, N. Y. When the United States entered the World War she volunteered as an army nurse and was detailed to organize army schools of nursing. At the close of the war she remained in the army nursing service and later became educational director of the City Hospital, Indianapolis. Following this association she became identified with Muhlenberg Hospital.

In addition to a rare executive ability which contributed greatly to the development of Muhlenburg, Miss Louis had many other interests which made her a prominent figure in the field. She was a charter member of the American College of Hospital Administrators and a former vice president of the American Hospital Association. Last year she retired as president of the New Jersey Hospital Association. Her great interest, too, in flowers, caused her garden at the hospital to be known throughout the countryside. This particular phase of her activities was described in an article "When the Hospital Goes in for Gardening" which appeared in the February issue of The MODERN HOSPITAL.

Mr. Howard brings to his new post extensive experience in hospital management. For three years he served as superintendent of the New York Hospital-Cornell Medical Center, New York City, and before that affiliation was identified for ten years with the New York Nursery and Child's Hospital and for five years with the New York Orthopedic Dispensary and Hospital, New York. Mr. Howard withdrew from the Cornell Medical Center a year ago.

Convalescent Hospitals Active

During its first year the convalescent hospital for men and boys operated by the New York Protestant Episcopal City Mission Society at West Park, New York, cared for 619 patients and gave 15,342 days of care. The three convalescent hospitals maintained by this same organization near New York have a bed capacity of 300 and cared for 1,693 patients last year.

Nebraska Passes Bill on Bureau of Nursing

The Nebraska nurses' bill to create a bureau of education and registration for nurses has been signed by the governor and will take effect three months from the date the legislature adjourns.

The bureau will be supported entirely by fees from licensing and registration. The state superintendent of public instruction will be ex officio president, and will appoint an educational director to act as secretary of the bureau and its two divisions, education and registration.

The committee on education will be composed of three members appointed by the governor from nominees made by the state nurses' association. The committee on registration, appointed in the same manner, will have from three to five members.

Low Death Rate Is Recorded

The lowest maternal rate in the 136 years of its existence was achieved by the Lying-In Hospital in New York City in 1934. Last year the hospital cared for 4,317 obstetric patients, among whom only six died, giving a gross maternal mortality of 1.38 per 1,000 discharged patients. Expressed in terms of live births, the maternal mortality rate was 1.7 per 1,000 live births. Of the 4,317 cases that received care, 3,336 were cared for in the hospital and 981 by the home delivery service. Those cared for at the time of delivery totaled 3,616. Nine out of every ten mothers returned for treatment and advice after the birth of their babies.

Pennsylvania Dietitians to Meet This Month

The third annual convention of the Pennsylvania State Dietetic Association is to be held May 8, 9 and 10 in Philadelphia, coinciding with the meeting of the Hospital Association of Pennsylvania. Joint meetings of the two organizations will be held when subjects of interest to both administrators and dietitians are discussed.

The program is planned to cover the four section activities, administration, diet therapy, professional education and community education. Educational and commercial exhibits will be open each day from nine to five.

Graduates and students of home economics schools not members of the association are invited to register as guests.

New Building Projects

TRAVERSE CITY, Mich.—A $75,000 children's clinic is to be erected on the grounds of the Traverse City State Hospital by means of a fund set up by Sen. James Couzens several years ago. The clinic will be the first of its kind in the northern part of the lower peninsula and will handle cases from Muskegon Bay north to the straits. A postgraduate teaching center will probably be established at the clinic by the University of Michigan Medical School.

DENTON, Tex.—One of the four buildings to be erected in the program authorized by PWA grants is a hospital under construction at the Texas State College for Women. It will cost approximately $35,000.

RIPON, Wis. — Contracts totaling $74,400 have been awarded for the Ripon Municipal Hospital.

KENEDY, Tex.—A sixteen-room hospital, with a modern operating room and a laboratory, is being built by Dr. C. M. Kent and Dr. John W. Worsham for the Kenedy Clinic and Hospital.

RICHMOND, Va.—A PWA grant of $130,000 has been received by the hospital division of the Medical College of Virginia for the erection of a central heating plant. The plant is designed to serve the present college and hospital buildings and any future developments. A series of underground tunnels, large enough to be used for passageways will connect all the buildings.

NAVASOTA, Tex.—An addition now under construction at Brazos Valley Sanitarium will provide a charity ward of twenty-five beds and expanded laboratory and operating facilities. Included in the building plans is a special room to house the library.

STATEN ISLAND, N. Y.—A new wing to be added to the Richmond Memorial Hospital, Princess Bay, will double the present capacity of the hospital which has an occupancy of forty-five beds. This addition will cost about $275,000 and will be two stories in height. It is the gift of Mrs. Berta Elizabeth Dreyfus who has been a generous contributor to the hospital since 1927, having made possible the main building, also a modern nurses' home.

DAYTON, Ohio.—In order to relieve the overcrowded conditions at Stillwater Sanatorium, the counties of Preble and Montgomery are asking aid from the FERA to permit the construction of a five-story addition, estimated at $200,000.

RACINE, Wis.—An annex and an administration building are being built at Sunny Rest Sanatorium through the auspices of the FERA. The total cost of the two projects is $60,000.

DEER LODGE, Mont.—A four-story receiving hospital is being built at the Montana State Tuberculosis Sanitarium at a cost of $134,990.

SHREVEPORT, La.—It is expected that the new Shreveport Charity Hospital will be completed by June 1. The institution, of which Dr. E. L. Sanderson is superintendent, will then have accommodations for 700 patients.

SAN ANTONIO, Tex.—Contracts have been awarded for two buildings in connection with the proposed army base hospital at Fort Sam Houston. One is a nurses' home, with facilities for housing fifty nurses and the other a medical detachment barracks to accommodate 200 men. Both buildings are to be of brick with artificial stone trim.

New York Group Plan to Cover 50-Mile Radius

Anyone living within a radius of fifty miles of New York City is eligible for membership in the three-cents-a-day Associated Hospital Service group hospitalization plan which went into effect in April under the direction of Frank Van Dyk.

The plan does not accept indivdiual subscriptions. Dependents may be enrolled if they are included in a group of ten, five of whom must be regularly employed persons. In this manner the balance of the plan may be maintained. No one over sixty-five years of age may subscribe to the service, but the youngest child may be enrolled. No physical examination is required.

Subscribers must certify they are in normal health at the time they enter the plan. It is expected that membership in the service will reach 100,000 the first year and that it eventually will have 1,000,000 subscribers. There are now seventy-four hospitals cooperating in the plan.

Adopts Eight-Hour Plan

The eight-hour day for nurses has been adopted in the hospital division, Medical College of Virginia, Richmond, Va., beginning April 1. It is the first hospital in the state to adopt the eight-hour plan.

Allied Organizations Meet in Philadelphia

The Hospital Association of Pennsylvania, the Pennsylvania State Association of Nurse Anesthetists and the Pennsylvania State Dietetic Association are holding a joint convention in Philadelphia, May 8 to 10, at which an attendance of 1,000 is expected.

Those papers which are of joint interest to the hospital administrator and the anesthetist, are scheduled for Thursday afternoon when Dr. Edward Schumann, Philadelphia, will discuss the future of the nurse anesthetist and Dr. Harold Leighton Foss, George F. Geisinger Memorial Hospital, Danville, Pa., will talk on modern anesthesia from the standpoint of the surgeon.

On Friday afternoon the dietitians will meet with the hospital association. Pay cafeteria and dining room service for small and large hospitals is the subject of a talk that will be given by S. Margaret Gillam, New York Hospital, New York City. Dr. Joseph C. Doane, Jewish Hospital, Philadelphia, is to give a paper on the hospital dietitian.

Ready to Open in May

After numerous delays the Meadow Brook Hospital, Hempstead, N. Y., the first public hospital in Nassau County and the only institution in the county to have a ward for contagious diseases, is expected to open during May. The only chance for delay will be in the event that beds and surgical equipment cannot be obtained in time. Out of a planned total of 200 beds, only the contagious ward will be ready for patients, plus a few maternity and miscellaneous beds. It was voted to build the hospital five years ago, and the plan was to spend $1,900,000 on its construction. The depression cut into the expected sale of bonds, however, and it was impossible to complete the building.

Establishes Photography Department

A department of clinical photography has been established at the Saskatoon City Hospital, Saskatoon, Sask., to cover the field of motion pictures, natural color slides and photographs, memoscope films and lantern slides. The photographs are a part of the case record and are used for teaching in the school of nursing and at staff meetings. In three months the department has produced over 600 photographs. Leonard Shaw is the superintendent of the institution.

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Southern Hospital People Gather at Greensboro, N. C., in Tri-State Meeting

They actually ran short of representatives' identification badges at Greensboro, N. C., when the North Carolina Hospital Association met in joint meeting with the South Carolina and Virginia Hospital Associations. Attendance count reached the three hundred mark.

The two-day event was brimful of interest and activity for everyone. Subjects of papers read before the four sessions were carefully selected, emphasizing those phases of hospital conduct that present the greatest current problems. Down one flight from the convention hall a group of some twenty exhibitors put on a show of hospital equipment and supplies that was well attended and well patronized, too, according to the enthusiastic report of representatives in charge. The evening of the first day was the occasion of the annual banquet, always a high spot when good fellowship and true Southern hospitality abound.

Small Hospital Problems

The small hospital most concerned those who attended this meeting. Hence much of the discussion was aimed at assisting those responsible for the conduct of such institutions, as the following abstracts from certain talks will show.

"The Small Hospital as a Community Asset," by Maynard O. Fletcher, Tayloe Hospital, Washington, N. C.: "There are some communities in our beloved South that are beginning to realize that the hospital is an asset in its relation to the poor and needy. They feel that the indigent sick is a community liability that can be turned into an asset by the hospital, and, further, that the responsibility of creating this asset rests upon the community, not upon the hospital. . . . The hospital is also an asset as a business enterprise in the town."

"The Personal Side of the Hospital," by Dr. Lewis E. Jarrett, hospital division, Medical College of Virginia: "During this period of rapid modernization and improvement of service, have we kept in mind the personal feelings of our patients? At our hospital we attempt to make the patient feel that we are pleased he has chosen us. On entering, the patient is immediately referred to the superintendent or to one of his assistants. This person makes the financial arrangements and attends to details of admission, following which the administrative clerk performs the mechanical work and escorts the patient to his proper location. Among other courtesies rendered, the pastor of each patient admitted is extended a welcome to visit the patient at any time convenient to him. Personal letters are written patients after their release from the hospital expressing the hope that their stay was satisfactory. Also, a letter goes to the nearest relative in case of death. . . .Any special examination or transference of the patient to other departments is explained to him in advance."

"Hospital Publicity—Certain Types Debatable," by J. Lyman Melvin, Park View Hospital, Rocky Mount, N. C.: "Hospital publicity, unlike commercial advertising, does not create new markets of itself. We don't want the hospital to embark upon an era of rugged individualism. The public should be educated in hospital costs but not through ill-advised publicity which plays up the services of one particular institution against those of another."

"The Out-Patient Department as a Community Asset," by Mrs. Byrd B. Holmes, Greenville General Hospital, Greenville, S. C.: "It is the quality of the work done rather than the quantity that reflects credit upon the hospital. Proper equipment should be provided so that the doctor can proceed with his work without loss of time. The out-patient department plays an important part in the health and social life of the community."

The Anesthetist's Responsibility

"Pre-Anesthetic Preparation and the Anesthetist," by Edna M. Knight, Rex Hospital, Raleigh, N. C.: "Not every nurse is fitted to specialize in anesthesia. It is well to discourage or encourage as seems best those interested in this particular phase of the work. Personal contact by the anesthetist with the patient is desirable. Before the operation and during the administering of the anesthetic she should talk to the patient and encourage him."

"Legislation for Hospitals," by Dr. John S. Bradway, Legal Aid Clinic, Duke University, Durham, N. C.: "Preventive law like preventive medicine calls for initiative, but it is worth while in the long run. In organizing a legislative program it is first necessary to bring home to hospitals a consciousness of the need for cooperating with the law in solving problems that at first sight may seem to lie exclusively in the hospital field. Then it is necessary to canvass the existing laws to find out just how many of the activities of the hospitals are already covered by one or more rules of law."

Newton Fisher, James Walker Memorial Hospital, Wilmington, N. C., president, North Carolina Hospital Association, presided at two sessions while Dr. W. T. Sanger, president, Virginia Hospital Association and F. Oliver Bates, president, South Carolina Hospital Association, served as the other presiding officers.

Those on the Program

In addition to the speakers, abstracts of whose talks have been presented, the program included the following names: Dr. J. F. Highsmith, Sr., Highsmith Hospital, Fayetteville, N. C.; Marybeth Hurst, Grace Hospital, Banner Elk, N. C.; B. W. Rogers, Watts Hospital, Durham, N. C.; T. J. Alford, Roanoke Rapids Hospital, Roanoke Rapids, N. C.; Dr. Henry J. Langston, Danville, Va.; Helen Roll, Johnston-Willis Hospital, Richmond, Va.; Ruth Council, president, North Carolina State Nurses' Association, Charlotte, N. C.; Mrs. Mary F. Hearn, Rex Hospital, Raleigh, N. C.; Dr. F. H. Mayfield, hospital division, Medical College of Virginia; Lela M. Davis, Tuomey Hospital, Sumter, S. C.; F. V. Altvater, superintendent, Duke Hospital, Durham, N. C.; Dr. J. B. Whittington, City Memorial Hospital, Winston-Salem, N. C.; Charles H. Dabbs, Tuomey Hospital, Sumter, S. C.; Dr. J. M. Shackelford, Shackelford Hospital, Martinsdale, Va.; Dr. I. H. Manning, Chapel Hill, N. C.; Dr. Robert W. Petrie, Petrie Hospital, Murphy, N. C.

Among prominent visitors attending the convention were Dr. Bert W. Caldwell, executive secretary, American Hospital Association and Robert E. Neff, president, American College of Hospital Administrators. In addition to recounting the progress of the legislative work being carried on at Washington under the auspices of the A. H. A., Doctor Caldwell conducted a round table on hospital problems.

Mr. Neff was the guest speaker at the banquet, selecting as his subject "Better Standards for Hospital Administrators."

Dr. Boice C. Wills, Park View Hospital, Rocky Mount, N. C., was elected president of the North Carolina Hospital Association succeeding Newton Fisher. M. E. Winston, Rex Hospital, Raleigh, was reelected secretary and treasurer. Dr. Lewis E. Jarrett, was elected president of the Virginia group and M. Haskins Coleman, Jr., Johnston Willis Hospital, Richmond, secretary.

Summer Dietetic Course at New York-Cornell

A field practice course at New York Hospital and Cornell University Medical School is open to those who qualify for appointment. This course, which is under the supervision of Dr. Mary deGarmo Bryan, institution management, Teachers College, Columbia University, and S. Margaret Gillam, director, department of nutrition, New York Hospital, offers observation in all units of the nutrition department of the institution which has a bed capacity of 1,000 and cares for all types of acutely ill patients.

Lectures and clinics will be conducted by physicians on the staff of the New York Hospital and of Cornell University Medical School and by members of the staff of the nutrition department. Requirements are a college degree with a major in foods and nutrition or institution management, hospital training and experience satisfactory to the advisers.

A limited number of appointments will be reserved for college instructors in diet in disease.

Legislation

OKLAHOMA.—Liens on all rights of action, claims, judgments, compromises or settlements accruing to injured persons by reason of their injuries will be accorded to physicians, nurses and hospitals treating persons injured through the negligence of others, if a bill introduced is passed.

QUEBEC.—A bill presented to the Provincial legislature provides that when a settlement is made to a claimant in respect of an automobile accident, at the time of settling the claimant's claim, the bill for hospitalization and medical services accorded the injured party will be paid by the party or corporation making the settlement. Since this bill has the approval of the committee on public bills, it is expected that it will become a law at the present sitting of Parliament and the Provincial Legislative Council.

PENNSYLVANIA.—A bill providing reimbursement for hospital care of indigent persons injured by motors on the highways has been introduced before the senate.

MARYLAND.—A bill has passed the senate which proposes to authorize corporations to organize under the corporation laws of the state for the purpose of operating a nonprofit hospital service plan.

MINNESOTA.—A proposal to amend the law relating to the care, treatment and hospitalization of indigents by permitting the county board of any county in which there is located a hospital designated as a Class A hospital by the American College of Surgeons to contract with such hospitals to care for and treat indigent residents of the county, has been introduced before the state legislature.

NORTH CAROLINA.—A bill recently introduced proposes to exempt from taxation all general hospitals operating approved nurses' training schools.

Bequests

A gift of $200,000 has been made to the funds of Royal Victoria Hospital, Montreal, Que., by Sir Herbert Holt, president of the hospital. The gift is to be known as the Herbert S. Holt Foundation.

The French Hospital of New York City and Monmouth Memorial Hospital, Long Branch, N. J., have received bequests from the estate of John Hubbard, retired lawyer and former treasurer of the International Banking Corporation. A total of $277,424, representing three-fourths of the residue of the estate, is to be divided among four institutions of which the two hospitals mentioned are each to receive four-tenths.

A trust fund has been established by the will of the late Dornoe E. Parker, of Wales, Mass., which, when it reaches over $1,000,000, will be used to establish the Dornoe E. Parker and the Fannie M. Parker Memorial Hospital, a public institution for Monson, Mass. Among those receiving one-sixth of the income from a $6,000 trust fund provided by the will are the Home for the Aged and Palmer Hospital.

More than three-fourths of the $234,147 net estate left by Dr. William Chittenden Lusk goes to New York University and Bellevue Hospital Medical College. The sums of more than $180,000 eventually allotted to the college by Doctor Lusk, who was a professor at the institution, are to set up the Chittenden Lusk Fund for the Advancement of Medical and Surgical Science. Doctor Lusk's father, Dr. William Thompson Lusk, was a former president of the college.

Greenville Darke County Hospital, Greenville, Ohio, recently received $250 from the estate of the late Dr. Ora I. Hetzler. A 200-acre farm near Stony Creek, Ind., was left by Doctor Hetzler to the James Whitcomb Riley Hospital for Children, Indianapolis, with the stipulation that it be held in trust for the testator's father, Gideon Hetzler, until his death.

A large portion of the $2,000,000 estate of Jep J. Dau, Chicago, is to become a trust fund. One-fifth of the income from this fund will be divided equally between the Chicago Home for Incurables, the United Charities of Chicago, the Children's Memorial Hospital and the Young Women's Christian Association. The remaining four-fifths is to be divided equally between the Danish Old People's Home of Chicago and the Chicago Orphan Asylum.

A bequest of $68,000 made to the Monmouth Memorial Hospital, Long Branch, N. J., from the estate of the late John Hubbard is to be used in the construction of a new laundry and power plant. Mr. Hubbard stipulated that the money be used to modernize the present antiquated plant, which is more than a quarter of a century old. Plans are being completed by Epple & Kahrs, architects in Newark, N. J., and it is expected that ground will be broken this spring.

The Children's Hospital, Halifax, N. S., will receive 20 per cent of the income from the trust fund established by the will of the late Obed E. Smith from his $2,000,000 estate, after bequests to his family have been paid. Grace Maternity Hospital, Halifax, and Inverness County Memorial Hospital, Inverness, will each receive 5 per cent.

St. John's Riverside Hospital, Yonkers, N. Y., is the recipient of a gift of $150,000 made by the Surdna Foundation which was established some years ago by the late John E. Andrus, capitalist. From the same source the Yonkers General Hospital and St. Joseph's Hospital, Yonkers, each receives $25,000.

The United Hospital Fund and the Charity Organization Society, both of New York, will each receive one-quarter of the estate of the late Bernhard C. Hesse, appraised at $123,073. The other half will be divided equally between the University of Chicago and the University of Michigan.

An outright gift of $37,500 was left to Good Samaritan Hospital, Portland, Ore., by the late W. B. Ayers.

St. Luke's Hospital, Chicago, receives $25,000, and the Cape Cod Hospital, Hyannis, Mass., $10,000 through the will of the late Robert Marshall Roloson of Evanston, Ill.

The late Dr. Harry A. Sifton, chief of staff of the Milwaukee Hospital (Passavant), Milwaukee, for twenty-five years, left his estate of $350,000 to the hospital with the stipulation that before it became the property of the institution, certain named beneficiaries were to be allowed the use of the income from the estate for as long as they lived.

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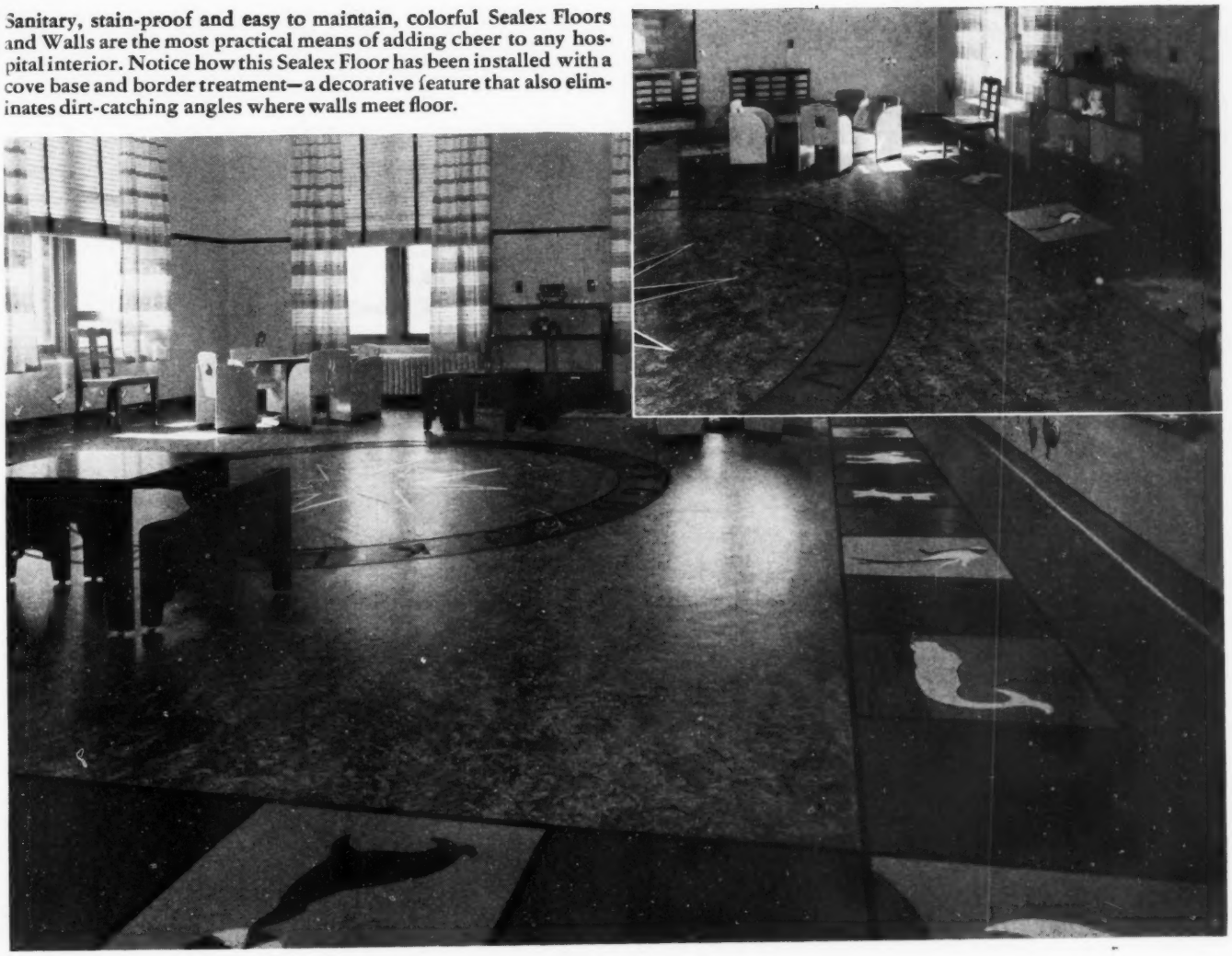

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Goldwater Continues Drive for Research and Hospitalization in Chronic Disease

The drive for proper hospitalization of patients suffering from chronic diseases and for research facilities to be used in arresting the progress of this type of invalidism continues in New York City under the direction of Dr. S. S. Goldwater.

Efforts are being made to obtain a fund of $25,000 from private agencies to be used to start research work on chronic diseases at once. An $11,000 response had been made to Doctor Goldwater's requests by April 1. The work will be begun experimentally with 100 beds in the Metropolitan Hospital on Welfare Island.

Mayor La Guardia has sponsored a request for PWA funds for the construction of two modern hospitals for chronic diseases, each with a capacity of 1,500 beds, to be erected on Welfare Island.

Systematic efforts are being made by Doctor Goldwater and his aids to create a proper understanding of the needs for an increased appropriation for maintenance, laboratory service and nursing care, on the part of the board of estimate and apportionment, the board of aldermen, the budget director's office and the public.

The preliminary fund of $25,000 for the inauguration of the research work is being asked with the belief that a show of interest and approval on the part of citizens and organizations will encourage official action on the 1936 budget, which will have to provide the funds necessary to continue the work, as it is not intended that this project should rely upon private sources for financing.

The deans of the five medical schools in New York City have united in support of Doctor Goldwater and the movement. It is planned that eventually a clinical division in a chronic hospital will be assigned to each school.

It has been estimated, according to Doctor Goldwater, that $100,000 would be needed annually to open and maintain the new division, but that a saving of millions of dollars would be made by the city as the result of a checking of prospective chronic cases soon after incipiency.

Texas Associations Elect New Officers

Two Texas hospital associations held meetings during the month of March at which officers for the coming year were elected.

The Texas State Hospital Association, which met at Marlin on March 22 and 23, elected E. M. Collier, superintendent, West Texas Baptist Sanitarium, Abilene, president, and Mrs. Martha Roberson, superintendent, Medical and Surgical Hospital, San Antonio, president-elect.

The other officers selected were C. E. Hunt, superintendent, Lubbock Sanitarium, Lubbock, first vice president, Oswald Daughety, Central Texas Hospital, Brownwood, second vice president, and Margaret Rose, Wichita Falls General Hospital, Wichita Falls, secretary. Mrs. Josie Roberts, superintendent, Methodist Hospital, Houston, was reelected treasurer.

The Northwest Texas Clinic and Hospital Managers Association held their meeting in Brownwood on March 21. Eva M. Wallace, superintendent, Wichita Falls Clinic Hospital, Wichita Falls, was elected president.

J. B. Adcock, business manager, Rush, Schulkey, Wall and Windham Clinic Hospital, San Angelo, was made first vice president. Pat Morrison, business manager, West Texas Baptist Hospital, Abilene, was chosen secretary-treasurer.

Johns Hopkins Hospital Opens $200,000 Drive

An appeal for funds amounting to $200,000 is being made by Johns Hopkins Hospital, Baltimore. This is the first time in the history of the forty-six-year-old institution that a campaign for funds has been found necessary.

Decreases in the net income of the hospital have already forced the closing of 100 beds. "We could either curtail expenses still further to prevent continuing deficits," explained Henry D. Harlan, president of the board, "or we could appeal to the people of Baltimore for whom Johns Hopkins founded the hospital and in whose service the present financial need arises.

"Because further curtailments can be made only at the expense of the sick poor whose needs today are greater than ever, the second alternative could be our only choice." The drive was opened on April 24.

Nurse Anesthetists to Meet With Hospital Groups

Two meetings of state associations of nurse anesthetists are scheduled for this month in conjunction with hospital association meetings. The fourth annual meeting of the Pennsylvania State Association of Nurse Anesthetists is to be held with the Pennsylvania Hospital Association in Philadelphia, May 8 to 10, and the New York State Association is meeting with the New York Hospital Association in New York City, May 23 and 24.

On June 20 and 21, at Duluth, Minn., the first annual meeting of the Minnesota State Association of Nurse Anesthetists will be held in conjuction with the Minnesota Hospital Association.

The National Association of Nurse Anesthetists will be held in St. Louis, October 1 to 3, in conjunction with the convention of the A. H. A.

New Record Achieved by Englewood Hospital

A general increase in the demand for medical, surgical and maternity care at Englewood Hospital, Englewood, N. J., has resulted in new records in the number of patients being treated. The hospital census recently reached a total of 240 patients, surpassing the previous record of 227 patients registered at the hospital on February 23.

The new maternity wing which has recently been opened has made it possible to accommodate a large number of maternity cases without overcrowding, according to Victoria Smith, superintendent. In other departments, however, it has been necessary to convert double rooms into rooms with four beds and to place additional beds in all wards.

Miss Smith also reveals that the maternity ward policy of admitting only fathers of newborn children as visitors is to be continued. This policy was instituted following the recent deaths of ten newborn babies in Teaneck, N. J., as a result of a strange intestinal ailment.

Solicitor on Business Staff

A solicitor has been engaged as a permanent part of the business staff of the Saskatoon City Hospital, Saskatoon, Sask. It is thought that his services will prove to be an aid to the hospital in its collection policies, and will be of protective value to the institution generally.

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CHICAGO PHILADELPHIA MONTREAL

Costs of 24 Catholic Hospitals Jump $249,036 in Year

A sum of $3,605,176 was expended in 1934 for operating cost by the twenty-four general and special Catholic hospitals, which include seven clinics, in the Roman Catholic Archdiocese of New York, according to the annual report of the division of health of the Catholic Charities. In 1933 the cost was $249,036 less than this.

Over 350,000 days of free care were given to about 12,000 patients at a cost of $1,759,530. This is almost twice the amount collected in the annual drive by Catholic Charities for the year. In-patients numbered 54,650, an increase of almost 3,000 over 1933. Regular hospital rates were paid by 32 per cent of these, about an equal number were paid for by New York City at rates less than the cost of their care, a little more than 14 per cent paid in part and 21 per cent paid nothing.

In the seven hospitals with clinics, 39,459 patients were treated. This was an increase of almost 2,000 over the number treated in 1933. In 18,598 cases, free prescriptions were given to needy patients. Clinical care totaled 159,684 visits, an increase of 24,481 over those made in 1933.

Hospital Establishes New Record

Nineteen thirty-four proved an outstanding year in the work of the Woman's Hospital in New York City in that not a single loss of life was reported among the 814 mothers attending its prenatal clinic. This is the first year that has passed without any maternal fatality since the inception of the hospital's obstetric service twenty-five years ago. The record reveals that 16,102 patients were cared for during the year, of whom 5,064 were in-patients. These received a total of 73,085 days' care of which 35,246 were free. The out-patient class numbered 11,038.

Eight-Hour Day Brings Employment Increase

An increase of employment among nurses, from 25 per cent to 90 per cent, is reported by the committee on eight hours for nurses, representing the New York State Nurses Association for Manhattan, the Bronx, Westchester County and Staten Island, following the introduction of the eight-hour day schedule for nurses in New York City.

Nearly 2,500 private duty nurses, over one-third of those practicing in the city are now connected with hospitals that permit them to work the short hours. Twenty-five hospitals in the city have adopted the eight-hour schedule for special nurses.

Three nurses instead of two are employed when twenty-four-hour service is required, consequently the plan permits shorter units of nursing service at a lower fee, a reasonable working day for three nurses and more days' work.

Georgia Librarians Meet

The Georgia division of the Association of Record Librarians has been holding monthly meetings in an effort to become as thoroughly organized as it wishes to be. The division now has twelve active members and two honorary. Mrs. E. A. Hamrick, Grady Hospital, Atlanta, is president, and Nannie Belle Phillips, Henrietta Egleston Hospital for Children, is secretary-treasurer.

Plans Formulated for New Building

Plans are being drawn for a modern fireproof building to replace Wards K and L of Fairmont Hospital of Alameda County, San Leandro, Calif. It is hoped that if the county provides plans, specifications, materials and supervision the state emergency relief administration will provide the labor.

Doctors Administer Anesthetics

As the result of a plan being tried experimentally at Bellevue Hospital, New York City, graduates of medicine rather than nurse technicians will administer anesthetics. If the plan proves successful, it will be instituted in the other twenty-five city hospitals. Advances in surgery have been accompanied by demands for more skill and different techniques in anesthetizing patients, Dr. S. S. Goldwater, commissioner of hospitals, explained when discussing this move, and the lack of broad training in medicine of nurses disqualifies them for administering spinal injections and other forms of anesthetics aside from the inhalation methods used for ether and nitrous oxide, he said.

Nursing Education Appointments

Dorothy Rogers has been appointed assistant professor of nursing education and Sallie L. Mernin is to be an instructor in nursing education on the staff of the University of Chicago, effective with the opening of the summer quarter courses in nursing education. Miss Rogers is now director of the John Sealy College of Nursing at the University of Texas and Miss Mernin has been instructor and supervisor of supplementary and graduate courses at the Stanford School of Nursing in San Francisco.

Denver Hospitals Adopt Rules Regulating Information on Discharged Patients

The Denver Council of Hospitals has adopted a series of rules for record rooms, formulated to cope with situations arising from the demands for information made by insurance companies, physicians representing insurance companies and other individuals, regarding hospital cases. The rules, which went into effect in January, do not affect information given to friends, relatives or the press regarding the condition of the patient.

Assembled to protect the hospital from requests for information to be used for legal or other purposes after the patient has been discharged, the rules provide that no chart be shown an insurance company, a corporation or any individual other than the doctor representing the patient. Information is given to these persons only when their requests are accompanied by the signed consent of the patient, or, in case of death, the patient's nearest relative, and the attending doctor.

Information, when given out, includes the name, age, and address of the patient, date of admission, diagnosis, report of x-ray and laboratory examinations, date and name of operation, doctor operating, date of discharge and condition on discharge. Any of this may be omitted at the discretion of the hospital.

A charge of not less than two dollars is made for each report. Any doctor, hospital or other agency wanting information from the chart of a patient entered in the hospital under another doctor is referred to the original attending doctor. No information is given over the telephone to any company or individual regarding a discharged private patient except the dates of admission and discharge and the address of the patient.

5,000 Years of Surgical Instruments

Thousands of years ago, far back in the Neolithic Stone Age, laboring with crude instruments of flint, unskilled witch doctors were already performing the operation of trephining. By 2250 B. C. surgery had so far advanced that Hammurabi's Code contained specific rewards and penalties for success or failure in delicate operations on the eye. And yet, until the beginning of the 18th century the surgeon had to depend on the coppersmith, the armourer and the maker of weapons for his instruments, many of which of necessity were of his own design. . . . Today the making of surgical instruments has become a fine art, a profession in itself; and the maker of instruments has become chief marshal of the surgeon in the long fight against disease.

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Auto Accident Cases Cause $135,000 Loss

Approximately 5,200 automobile accident patients were treated by hospitals in North Carolina at a loss of $135,000 during the year 1934, according to a report made by Newton Fisher, superintendent, James Walker Memorial Hospital, Wilmington, N. C., at a recent meeting of most of the hospitals in the eastern part of the state.

The report, based upon questionnaires sent by Mr. Fisher to hospitals in the state, brought forth that an average of 150 such patients are cared for daily by the hospitals at a partial or complete loss. These returns do not include the work done entirely without charge in emergency rooms on those patients not seriously enough injured to require hospitalization.

The suggestion was made that the state highway commission be asked to absorb the loss as it does in Ohio, but the consensus of opinion at the meeting was that a request to the General Assembly of North Carolina for the provision of some agency other than the hospitals to carry this expense would not meet with success at present.

Installs Reference Bureau

A reference bureau in which general practitioners and specialists are classified and indexed has been placed in operation by the Chicago Medical Society for the benefit of the public. Formerly, when calls for a physician came to the society they were denied, but now an inquirer will be referred to a physician in his own neighborhood. No charge is made for this service and physicians who belong to the bureau are called in rotation.

Bureau Centralizes Admissions

A bureau that will center and coordinate free and part-pay admissions to hospitals and clinics has been set up in Washington, D. C., with the cooperation of the community chest, the local medical and dental associations, the District of Columbia Hospital Superintendents' Association, the council of social agencies and the board of public welfare. Named the Medical Admitting Bureau, it has a first-year budget of approximately $20,000 that will be met by the community chest from appropriations to hospitals. Ross Garrett, health secretary of the council of social agencies, is the director of the bureau. It has been estimated that a saving of $60,000 will be made through the elimination of unnecessary demands made by patients for free and part-pay care.

Coming Meetings

Joint Meeting Illinois, Indiana and Wisconsin Hospital Associations.
Chicago, May 1-3.

Hospital Association of Methodist Episcopal Church, South.
President, R. S. Hudgens, Emory University, Ga.
Secretary, Sadie Morrison, Wesley Memorial Building, Atlanta, Ga.
Next meeting, Nashville, Tenn., May 6-7.

Arkansas Hospital Association.
President, Msgr. J. P. Fisher, Little Rock.
Secretary, Regina H. Kaplan, Leo N. Levi Memorial Hospital, Hot Springs National Park.
Next meeting, Little Rock, May 7.

Hospital Association of Pennsylvania.
President, Charles A. Gill, Episcopal Hospital, Philadelphia.
Executive secretary, John N. Hatfield, Pennsylvania Hospital, Philadelphia.
Next meeting, Philadelphia, May 8-10.

Michigan Hospital Association.
President, Dr. Warren L. Babcock, Grace Hospital, Detroit.
Secretary, Robert G. Greve, University Hospital, Ann Arbor.
Next meeting, Jackson, May 9-10.

Mississippi Hospital Association.
President, Dr. R. J. Field, Field Memorial Hospital, Centreville.
Secretary, Dr. Leon S. Lippincott, Vicksburg Sanitarium, Vicksburg.
Next meeting, Biloxi, May 13.

International Hospital Association.
Next meeting, Rome, Italy, May 19-25.

Hospital Association of New York State.
President, P. Godfrey Savage, Niagara Falls Memorial Hospital, Niagara Falls.
Executive secretary, Carl P. Wright, General Hospital of Syracuse, Syracuse.
Next meeting, New York City, May 23-24.

National League of Nursing Education.
President, Effie J. Taylor, New Haven, Conn.
Executive secretary, Claribel A. Wheeler, 50 West Fiftieth Street, New York City.
Next meeting, New York City, June 3-8.

Mid-West Hospital Association.
President, Frank J. Walter, St. Luke's Hospital, Denver.
Executive secretary, Walter J. Grolton, City Hospital No. 1, St. Louis.
Next meeting, Colorado Springs, Colo., June 6-7.

Missouri State Hospital Association.
President, Walter J. Grolton, City Hospital No. 1, St. Louis.
Next meeting, Colorado Springs, Colo., June 6-7.

American Medical Association.
President, Dr. Walter L. Bierring, Des Moines, Iowa.
Secretary, Dr. Olin West, 535 North Dearborn Street, Chicago.
Next session, Atlantic City, N. J., June 10-14.

Canadian Medical Association.
President, Dr. J. S. McEachern, Calgary, Alta.
General secretary, Dr. T. C. Routley, 184 College Street, Toronto, Ont.
Next session, Atlantic City, N. J., June 10-14.

New Jersey Hospital Association.
President, William J. Ellis, Trenton.
Executive secretary, Rev. John G. Martin, Hospital of St. Barnabas and for Women and Children, Newark.
Next meeting, Atlantic City, June 14-15.

Catholic Hospital Association of the U S. and Canada.
President, Rev. Alphonse M. Schwitalla, S.J., St. Louis.
Executive secretary, M. R. Kneifl, 1402 South Grand Boulevard, St. Louis.
Next meeting, Omaha, Neb., June 17-21.

Hospital Association of Nova Scotia and Prince Edward Island.
President, Rev. H. G. Wright, Inverness, Nova Scotia.
Secretary, Anne Slattery, Dalhousie University, Halifax, Nova Scotia.
Next meeting, Wolfville, Nova Scotia, June 18-20.

Minnesota Hospital Association.
President, J. H. Mitchell, Colonial Hospital, Rochester.
Executive secretary, A. M. Calvin, Midway and Mounds Park Hospitals, St. Paul.
Next meeting, Duluth, June 20-21.

National Tuberculosis Association.
President, Kennon Dunham, Cincinnati.
Managing director, Dr. Kendall Emerson, 50 West Fiftieth Street, New York City.
Next meeting, Saranac Lake, N. Y., June 24-27.

Manitoba Hospital Association.
President, J. H. Metcalfe, Portage La Prairie.
Secretary, Dr. Gerald S. Williams, Children's Hospital, Winnipeg.
Next meeting, Dauphin, June 27-28.

American Protestant Hospital Association.
President, Dr. Charles C. Jarrell, 405 Wesley Memorial Building, Atlanta, Ga.
Executive secretary, E. E. Hanson, Lutheran Deaconess Home and Hospital, Chicago.
Next meeting, St. Louis, Sept. 27-30.

American College of Hospital Administrators.
President, Robert E. Neff, University of Iowa Hospitals, Iowa City, Iowa.
Director-general, J. Dewey Lutes, Ravenswood Hospital, Chicago.
Next meeting, St. Louis, Sept. 29-30.

American Hospital Association.
President, Robert Jolly, Memorial Hospital, Houston, Tex.
Executive secretary, Dr. Bert W. Caldwell, 18 East Division Street, Chicago.
Next meeting, St. Louis, Sept. 30-Oct. 4.

National Association of Nurse Anesthetists.
President, Gertrude L. Fife, 2065 Adelbert Road, Cleveland.
Next meeting, St. Louis, Oct. 1-3.

American Public Health Association.
President, Dr. Eugene L. Bishop, Nashville, Tenn.
Executive secretary, Dr. Reginald M. Atwater, 50 West Fiftieth Street, New York City.
Next meeting, Milwaukee, Oct. 7-10.

Ontario Hospital Association.
Pres. Brig. Gen. C. M. Nelles, C. M. G., Niagara-on-the-Lake.
Secretary-treasurer, Dr. Fred W. Routley, Maple.
Next meeting, Toronto, Oct. 15-17.

American Dietetic Association.
President, Laura Comstock, Rochester, N. Y.
Business manager, Dorothy I. Lenfest, 185 North Wabash Avenue, Chicago.
Next meeting, Cleveland, Oct. 28-31.

American College of Surgeons.
President, Dr. Robert B. Greenough, Boston.
Director-general, Dr. Franklin H. Martin, 40 East Erie Street, Chicago.
Next meeting, San Francisco, Oct. 28-Nov. 1.

Association of Record Librarians of North America.
President, Edna K. Huffman, St. Luke's Hospital, Davenport, Iowa.
Corresponding secretary, Helen Hays, St. Alexis Hospital, Cleveland.
Next meeting, San Francisco, Oct. 28-Nov. 1.

One-Twelfth of Chicago's Population Visited Hospitals in 1933, Survey Shows

Nearly $17,000,000 was spent in 1933 for hospital and clinic care in Chicago, according to a survey recently released by Samuel A. Goldsmith, chairman of the health division of the Chicago Council of Social Agencies. The survey was made under the direction of Mr. Goldsmith and Alexander Ropchan, of the health division.

The income of hospitals in 1933 (excluding the unattached clinics) was $15,215,000. Patients paid 61 per cent of this, investments yielded 6 per cent, contributions, 3 per cent, public and semipublic relief funds, 3 per cent and tax support for government hospitals accounted for 26 per cent. Excluding the tax supported hospitals the percentages are changed as follows: patients' fees, 83 per cent, investment income, 8 per cent, contributions, 4 per cent, public and semipublic relief funds, 4 per cent and about 1 per cent from miscellaneous sources.

The average cost of hospital care for each patient is reported as $55 and the total cost of hospital and clinic care averaged almost $5 per capita of Chicago's population.

Chicago hospitals reduced per capita costs in spite of their reduced occupancy but they were not able to avoid deficits or to provide for regular replacements and maintenance, according to the survey. In 1933 there was an average of 6,000 empty beds in nongovernment hospitals in Chicago. Small hospitals and hospitals organized for profit were least successful in keeping their beds occupied.

Of 53 hospitals reporting on the item, 19 had no capital debts. The other 34 had loans and mortgages of $11,000,000 giving an average for the 53 hospitals of about $1,260 per bed. The interest alone on this debt represents a fixed cost of 42 cents per patient day.

Occupancy in the nongovernment hospitals in 1933 averaged 49 per cent and in the government hospitals, 88 per cent. Most of the beds in the nongovernment hospitals are in the higher price levels—56 per cent in rooms with one or two beds and only 25 per cent in wards with five or more beds. While most of the beds are for paying patients most of the patients cannot pay —of 9,672 patients in hospitals on February 7, 1934, 5,100 made no payment and between 600 and 700 paid only part of the cost.

More than one-twelfth of the population of Chicago received care in hospitals during 1933. Eighty-six per cent of the patients were residents of Chicago, 7 per cent of Chicago suburbs and only 7 per cent came from outside the metropolitan area.

Facilities for the care of convalescent and chronic patients are notably lacking, the report declared. Many of the patients in government hospitals fall into these classes.

New York State Hospital Group to Meet May 23-24

The Hospital Association of New York State will meet in New York City, May 23 and 24, under the leadership of P. Godfrey Savage, Niagara Falls Memorial Hospital, Niagara Falls, N. Y., president of the organization.

The business meeting of the association will be held Thursday morning, and on Thursday afternoon the papers will begin when Dr. Frederic E. Sondern, president, Medical Society of the State of New York, opens the meeting with a discussion on the relation of the hospital to the medical profession.

"The Hospital and the Practitioner," is the subject of the talk scheduled to be given by Dr. E. M. Bluestone, Montefiore Hospital for Chronic Diseases, New York City. Mary K. Taylor, social service department, Presbyterian Hospital, New York City, will speak on social service as it is needed in medical institutions. Dr. Frederick McCurdy, Vanderbilt Clinic, Columbia-Presbyterian Medical Center, New York City, will give a paper on the out-patient department.

Homer Wickenden, general director, United Hospital Fund of New York, will open the Friday morning sessions with a talk on group hospitalization, to be followed by Dr. C. W. Munger, Grasslands Hospital, Valhalla, whose subject is "Public Patients in Voluntary Hospitals."

Better standards for hospital administrators will be discussed by Robert E. Neff, president, American College of Hospital Administrators. "The Record Librarian," is the title of a paper being given by Huldah H. Ainsworth, president, New York State Association of Medical Record Librarians.

Rufus Rorem will give the report of the council on community relations and administrative practice of the American Hospital Association on Friday afternoon. Blanche Pfefferkorn, National League of Nursing Education, will give a paper on nursing. A round table discussion of administrative problems, conducted by Robert Jolly, president, American Hospital Association, will close the meeting.

General Hospital Builds Unit for Child Patients

A new unit has just been opened at the Protestant Deaconess Hospital, Evansville, Ind., as the result of a gift from Mr. and Mrs. John Giltner Igleheart, which was to be used to provide equipment sized to answer the requirements of children.

Situated on the floor above the solarium are the group of five rooms, and a surgery, treatment room and diet kitchen, which together compose the children's unit. Each room has at least two beds, so that none of the small patients may be lonely.

The two rooms for the larger children are done in a soft shade of green with beds, reading racks, adjustable tables and cabinets in corresponding shades. Contrast is achieved through colored bedspreads. Rooms for younger children are done in a creamy tan and their high sided beds are decorated with juvenile pictures and have rust colored spreads. One room also contains a bassinet in case a baby may need hospitalization.

A. G. Hahn is the business manager.

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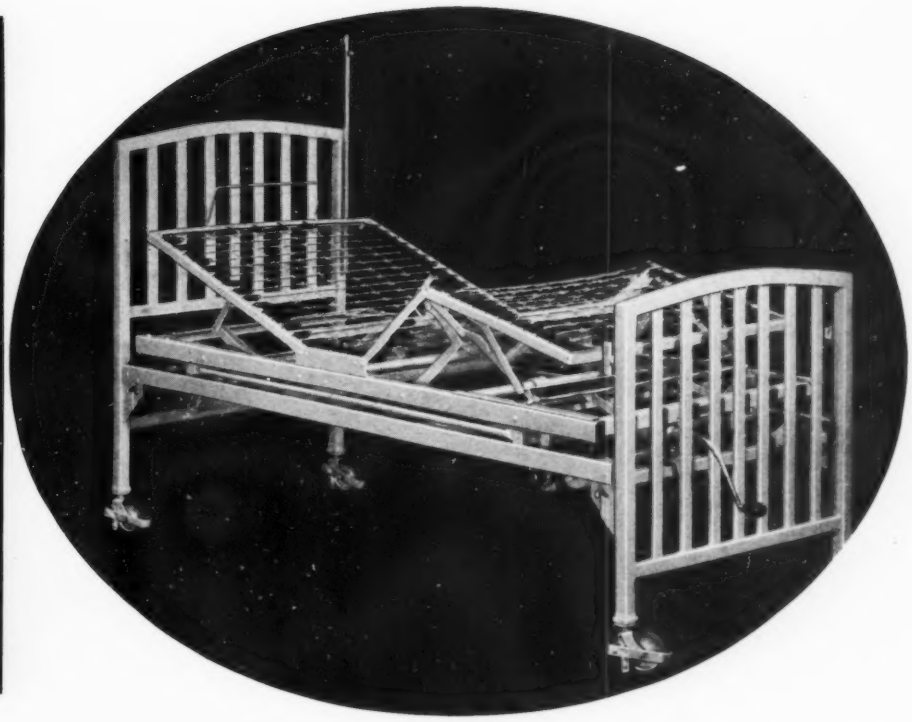
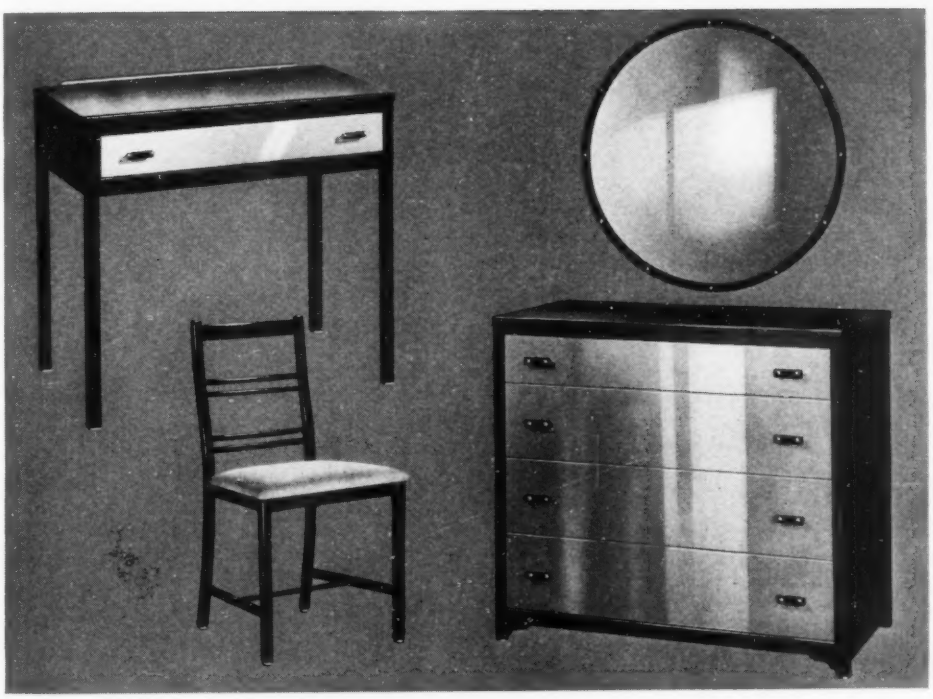
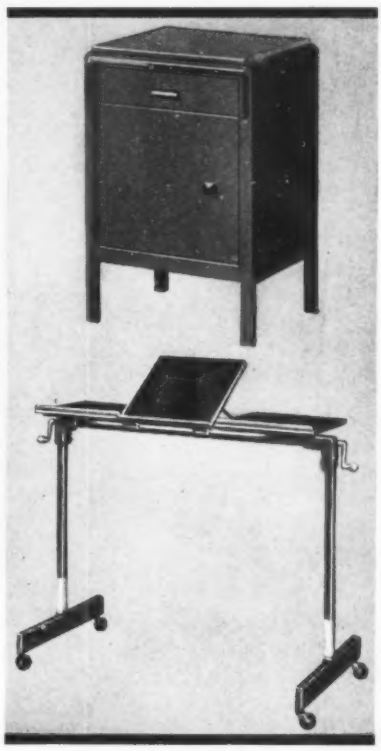


No. 16550 Bed—The spring bottom is mechanically operated for various positions, and is also mechanically operated for tilting, Trendelenberg and other positions.



No. 160 Dresser with No. 23176 Mirror—A beautiful modern style, made in several handsome finishes. **No. 160 Desk**—Modern design with white metal back rail. **No. 23172 Chair**—Modern design in choice of finishes and upholstery.



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PERSONALS

LUCY MINNIGERODE, superintendent of nurses of the United States Public Health Service, died on March 24 at the age of sixty-four. Miss Minnigerode was decorated with the Cross of St. Anne by the Czar of Russia for her services as a Red Cross Nurse at Kiev during 1914-15, and was awarded the Florence Nightingale Medal by the Red Cross in 1925. One of her books, "Instructions on Hygienic Methods," was translated into seven languages.

MADGE GRACE COOK, assistant practical instructress at Jersey City Medical Center, Jersey City, N. J., became superintendent of Tarrytown Hospital, Tarrytown, N. Y., on May 1. She succeeds AMELIA C. BALINSKI who resigned to become the wife of DR. PAUL RICHARDS.

MRS. DALE ROLL is the new superintendent of Davier Memorial Hospital, La Harpe, Ill.

LOUISE HIATT, who was made superintendent of Clinton County Hospital, Frankfort, Ind., when it opened in 1923, recently retired from the position because of ill health. RUTH HODGEN, assistant superintendent, is taking her place.

DR. DUDLEY T. DAWSON, superintendent of Alton State Hospital, Alton, Ill., has been appointed superintendent of Peoria State Hospital where he will succeed DR. GEORGE A. ZELLER.

JEANETTE M. DURANT, superintendent of Bristol Hospital, Bristol, Conn., died on Mar. 21, after an illness of two months.

MRS. CLARA E. BROWITT, superintendent of Greeley Hospital, Greeley, Colo., will resign on June 1.

RUTH BEAN has been appointed superintendent of Berkeley County Hospital, Moncks Corner, S. C. She succeeds MRS. ELMA Z. LORING.

DR. L. F. KNOEPP has been appointed medical director of Jefferson County Tuberculosis Hospital, Beaumont, Tex.

OTTO GREVE has been appointed superintendent of Sarah A. Jarman Hospital, Tuscola, Ill., which, closed in April, 1933, was recently reopened under county management.

V. MILDRED MILLER has joined the staff of Aultman Hospital, Canton, Ohio, as director of nursing. She fills the vacancy left by the death of MAUDE A. WOOD who was killed in an automobile accident several months ago.

DR. D. D. MONROE, superintendent of Madison County Sanitarium, Edwardsville, Ill., since its opening in 1926, has announced his resignation.

MRS. IAN BELL has been named superintendent of the new Garfield County Hospital, Glenwood Springs, Colo.

SISTER M. ANNA, superior of St. Elizabeth Hospital, Danville, Ill., for the past five years, died recently.

FLOURNOY HILL has been appointed superintendent of the newly opened Lister Hospital, New York City. Miss Hill was at one time assistant to LUCY M. MOORE, former superintendent of Knickerbocker Hospital, New York.

AUGUSTA ANN SMITH, superintendent of the South Highlands Infirmary, Birmingham, Ala., for seven years resigned recently. RHODA CARROLL, superintendent of nurses at the Good Samaritan Hospital, Lexington, Ky., has been appointed to take her place.

DR. ARTHUR N. BALL will succeed the late DR. EDWARD W. WHITNEY as superintendent of the Northampton State Hospital, Northampton, Mass. Doctor Ball has been a member of the state department of mental diseases for many years.

DR. WILLIAM WAIT has been appointed superintendent of the Western Oklahoma Tuberculosis Sanitarium, Clinton, Okla.

ELIZABETH C. BURGESS and LILLIAN A. HUDSON have been appointed professors of nursing education at Teachers College, Columbia University.

GERTRUDE GATES has been appointed superintendent of nurses at Prospect Heights Hospital, Brooklyn, N. Y. Miss Gates was formerly instructress at the United Hospital, Port Chester, N. Y.

DR. R. DEL. JOHNSON, for the last two years a member of the radiologic staff of Vancouver General Hospital, Vancouver, B. C., has joined the staff of St. Paul's Hospital, Saskatoon, Sask., as radiologist.

ROBERT T. JOHNSON, Binghamton, N. Y., has been appointed superintendent of Ideal Hospital, Endicott, N. Y., to fill the post left vacant by the resignation of MANDEL R. ABRAHAMS.

DR. KNOWLTON T. REDFIELD has resigned as superintendent of the Norfolk Protestant Hospital, Norfolk, Va.

DR. EUGENE B. ELDER, superintendent of the Knoxville General Hospital, Knoxville, Tenn., has been appointed superintendent and general manager of the Baroness Erlanger Hospital, Chattanooga, Tenn. HARRIET PEARSON, who has been superintendent of the Erlanger Hospital since 1905, has been appointed superintendent and director of nurses. The change becomes effective June 1.

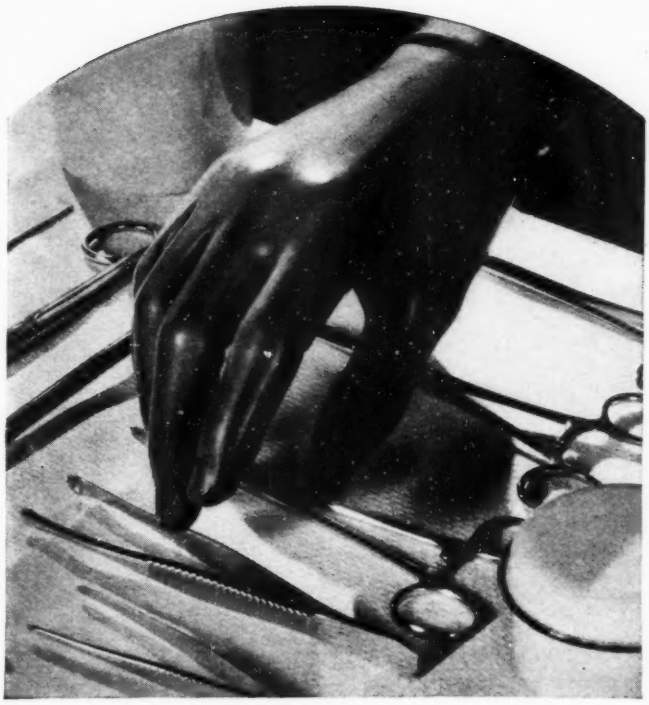
F. J. MCCARTHY, business manager, Berwyn Hospital, Berwyn, Ill., should be credited with the carrying out of the many improvements at the hospital, reported in the April issue. OMA M. KULL, formerly superintendent, is no longer connected with the institution.

MRS. JANET FENIMORE KORNGOLD, superintendent of nurses, Touro Infirmary, New Orleans, for the last six years, has been appointed to fill a similar position at St. Luke's Hospital, Chicago.

Dr. MacLean to Succeed Dr. Faxon

Announcement has been made by the president of the University of Rochester of the appointment of Dr. Basil C. MacLean, superintendent of Touro Infirmary, New Orleans, as director of Strong Memorial Hospital, Rochester,

N. Y. He will succeed Dr. Nathaniel W. Faxon, who resigned in February to accept the post of director of Massachusetts General Hospital, Boston. Doctor MacLean graduated from McGill University, Montreal, in 1927. After three years' administrative work in Montreal General Hospital, under Dr. A. K. Haywood, he became, in 1930, superintendent of Touro Infirmary. He is chairman of the committee on accounting of the American Hospital Association and a member of the association's council on community relations and administrative practice.



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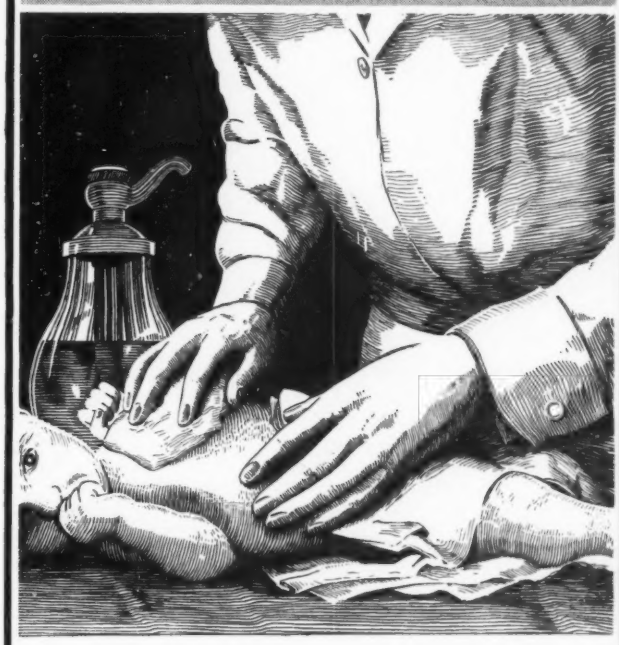

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CORRESPONDENCE

A Complete Failure

Sirs:

After carefully studying your architectural adviser's comment on the "Small Hospital" plans appearing in the March issue, I am left wondering just why you published the drawings at all, if they were so bad.

As a cover to cover reader of The MODERN HOSPITAL since 1913, I must confess that the March issue from an architectural standpoint was a complete failure. Not one of the published drawings received a 100 per cent favorable comment.

There have been many splendidly planned small hospitals, constructed during the past few years, and I hope The MODERN HOSPITAL in the near future will attempt another "Small Hospital" issue containing some of these which will serve some good purpose.

H. P. VAN ARSDALL.
Samuel Hannaford & Sons,
Cincinnati.

Of Paramount Importance

Sirs:

I have just received the March copy of The MODERN HOSPITAL and have thoroughly absorbed your "Portfolio of Small Hospitals."

Permit me to say that I regard this section as of paramount importance to all in the hospital field. Far too many mistakes are made in hospital planning, and I am of the firm opinion that your criticism is of such importance that its value cannot be overestimated.

ALBERT H. BOREN,
Architect.
Dallas, Tex.

"Grousing About Board Members"

Sirs:

I was interested in an article in your March number entitled "How to Recognize a Good Trustee." The material is excellent, but the weakness of it is that it has to be said apparently by a hospital person and appears in a hospital magazine where it will not be read by the trustee group, for which it is really intended.

Would it be possible for such an idea to be put in a new form and offered to some magazine like the *Atlantic Monthly* or one of the women's magazines in which it might be reviewed in the *Reader's Digest?*

So far as we superintendents go, the less time we spend grousing about board members the better, but if some hospital president . . . or someone with a national reputation should say the same things, presumably at a public address, the effect might be very great.

F. STANLEY HOWE,
Director.
Orange Memorial Hospital,
Orange, N. J.

Grievous Errors Overlooked

Sirs:

I desire to offer some comment on the practice recently inaugurated by The MODERN HOSPITAL of publishing the plans of new or proposed hospitals, followed by their critical analysis.

While this is a step in the right direction, the value of the exposition could be measurably enhanced if all such plans could be criticized exclusively by seasoned hospital administrators rather than architects, since the hospital field is much less interested in architecture and engineering details than it is in the functional features of the plans.

I have studied all material presented since you have inaugurated this practice and note with regret that, as might be anticipated, the most grievous errors in functional planning have been entirely overlooked by your architect critics, thereby creating the impression that, with the exception of the architectural matters commented upon, the plans were functionally correct.

In the case of the operating pavilion submitted by an architect and a surgeon a few months ago, it is a pity that those plans were not submitted to a qualified hospital administrator before publication, in which case I am inclined to think the article would have never seen the light of day.

The plans, as well as the criticism, of the Jewish Hospital of Montreal are of little value because the whole plan was neither submitted to the critic nor published. It is obvious that no intelligent criticism can be offered on the plans of a multistoried hospital when only the plans of two floors are scrutinized.

The only criterion of the perfection of hospital plans is the efficiency and economy of operation of the institution, and it would seem to be the consensus of opinion of those who have had any experience in hospital work that the able hospital administrator, rather than the architect, is the one best qualified to pass upon those functional details which so vitally affect the final result.

WILLIAM H. WALSH, M.D.
Chicago.

Doctor Walsh's thesis that only hospital administrators are competent to criticize architectural plans merits further discussion. What say the architects? And the hospital administrators and consultants?—*Ed.*

Occupancy Overplayed

Sirs:

I have just read Doctor Buerki's article carefully and with some of his positions I agree and with some I disagree.

First, I think we shall see in the next ten, twenty or thirty years a tremendous expansion of the out-patient services of hospitals. In fact, it is possible that in time the out-patient service will be looked upon as more important than the in-patient service. That means, of course, that the hospital, which is essentially organized medicine, will absorb more and more of the work now done by general practitioners. As this development takes place, the hospitals should absorb a larger proportion of the medical profession, and the members of the profession rendering service in the out-patient department will probably be remunerated. . . .

I am in complete accord with Doctor Buerki's idea as to the mild diseases being more harmful as a whole to the human race than the more dangerous fatal diseases. . . .

As to the duplication of equipment, I am not so sure that that is a matter of any major importance at present. It is true that doctors who have access to hospitals and an excellent radiologic service will purchase small units of such a service for their own private offices, but considering the convenience of readily accessible equipment and the saving of the doctor's time, on the one hand, and the larger investment and the use of pooled equipment on the other hand, I do not believe this to be a matter of major importance. . . . Moreover if it is important, it is restricted to the larger populations. . . .

As to hospital occupancy . . . I think this has been overplayed. In small general hospitals such as we have in the rural sections of the United States I regard an occupancy of 60 per cent as normal. That means in a county of 35,000 people with a hospital of 40 beds, that 24 beds are occupied at the average time and 16 are unoccupied. In short, for 35,000 people there is a surplus of only 16 beds. Moreover, a careful examination of the records of such an institution will show that on a number of occasions during the course of a year such a hospital carries from 40 to 45 patients, some of them in solariums and halls. Of course, in a city of 1,000,000 people with 5 beds per thousand population, or 5,000 beds, an occupancy of 75 per cent means that 3,750 beds are occupied and the city has a surplus of 1,250 beds, and that's very different. . . .

W. S. RANKIN, M.D.,
Director.
Hospital and Orphans Section,
The Duke Endowment,
Charlotte, N. C.

Integrate; Cooperate

Sirs:

I have read Doctor Buerki's article. In general I am in accord with its contents but have certain comments to offer.

That there is great waste of the large investment in American hospitals at the present time is obvious. The low occupancy of our institutions attests to this fact. This capital is fixed, however, and cannot be utilized in other directions. The problem here is to increase its use by bringing more patients to the hospital. There is general agreement that many in need of hospitalization cannot now obtain this service because of its cost.

I am in accord concerning the importance of providing competent and adequate care for the so-called minor and transitory illnesses which often undermine the individual's health. This is largely a question of the quality of professional service and a matter which in large part rests with the medical profession. Doctor Buerki's plea here would seem to be for extension of and better organization of our out-patient departments. For the most part this would entail new capital rather than redistribution of present capital funds. . . .

There can be little doubt that there is considerable duplication of capital investment as illustrated in the instance of private x-ray and clinical laboratory installations. Here again, the investments have been made and the capital is fixed. The plea should be against further unnecessary extension of such facilities. . . .

Hospitals can do no more than make available the essential facilities for adequate and competent professional service. It remains for the medical profession to make use of such facilities. . . .

It does appear to me that the questions raised by Doctor Buerki are important ones and that hospitals can approach their solution by:

1. Promoting friendly relations with the medical profession in their immediate vicinity. It seems to me that in these days it is important that hospitals be reminded of the fact that they are dependent upon the support of the medical profession. It is the physician who advises the patient to enter a hospital and it is the physician who is responsible for and who directs the professional service for the patient while in the hospital. There is no escape from this fact.
2. Integrating their service programs with the other hospitals of their community so as to provide adequate hospital service for the community, thus avoiding duplication and over-investment of capital funds in fixed structures and equipment and consequently an excessive need of funds for operation.
3. Integrating their programs with other health and social welfare agencies, so that a well balanced, comprehensive service can be developed for the entire community.
4. Establishing a plan whereby the cost of hospital service can be brought within the means of the average citizen, either through group hospitalization or some similar insurance plan.
5. Through cooperation with the medical profession extending the use of expensive diagnostic and therapeutic equipment to them and to their ambulatory as well as their hospitalized patients.

ARTHUR C. BACHMEYER, M.D.,
Director.
University of Chicago Clinics,
Chicago.

Common Sense Coordination

Sirs:

I read with interest the article which Doctor Buerki wrote entitled, "Do Your Capital Dollars Earn Full Service Dividends?" In this he has set forward in a slightly different manner the axiom that hospitals are, after all, community organizations and that the support of hospitals in one way or another ultimately becomes a charge on the community. Consequently in planning for existing hospitals or for future hospital expansion the matter should be considered not from the standpoint of advantage to the individual institution, but from the standpoint of the welfare of the community as a whole. . . .

Business has long ago recognized that a certain volume of operation or production is necessary in order to ensure a proper return on investments. The same is true with hospitals and hospital administration and it is generally recognized that occupancy of 75 to 80 per cent of hospital beds is necessary in order that a plant should be used in the most efficient way.

The present day problem of hospitals is twofold. First, how to increase the amount of service which hospitals may render to their communities, second, how to receive payment

for such service when rendered. The first may be attained by a greater use of voluntary hospitals for the care of those sick persons for whose hospital care the community accepts responsibility. The second may likewise be attained through payment for care of subscribers of group hospital plans from the insurance funds so collected, and by the payment from tax funds for service rendered to those sick for whom the community is responsible.

The working out of the relationships of private philanthropy, or public charity, tax supported responsibilities, voluntary hospitals, group hospitalization, the hospital care of the indigent and similar problems is really a matter of common sense coordination and a willingness to see both sides of the question.

N. W. FAXON,
Director.

Strong Memorial Hospital,
Rochester, N. Y.

Idiotic Bills

Sirs:

The Arkansas legislature is in session and numerous bills have been introduced that would affect all hospitals disadvantageously. Amongst these bills have been several that could be classified as idiotic. We have just succeeded in killing a bill that would have required all corporations to file quarterly report of any fees, deductions or retentions collected or held for the purpose of providing funds for insurance, medical service and attention, or sick benefits for employees, and to refund any money so collected to the employees from whom it was deducted.

A bill was introduced that would have made it impossible for hospitals to secure tax-free alcohol. Two bills have been introduced that would license certain laymen to practice medicine. We have been successful so far in blocking them or referring them to committees from which we hope the bills will not be reported further.

The hospital legislative committee combined with the medical, druggist and dental legislative committees, and through this group we have secured cooperation with certain other representation to give us added strength. . . .

LEE C. GAMMILL,
Superintendent.

Baptist State Hospital,
Little Rock, Ark.

Consideration, Courtesy, Naturalness

Sirs:

Enclosed is a copy of letter of appreciation that has just come to my desk. This, in my opinion, is a gem.

R. H. BISHOP, JR., M.D.,
Director.

University Hospitals,
Cleveland.

The letter is as follows: "In behalf of my wife, Charlotte, and responsive also to a self-engendered urge consequent upon ten visits by me in six days, I write to express our satisfaction with your service.

"Competency and efficiency are perhaps expectable, but, besides the soothing freedom from many needless prohibitions, we experienced those prerequisites to be happily mollified by the unobtrusive consideration, by the much more than perfunctory courtesy and by the trained habit of ingratiating naturalness of your staff.

"We have persuaded ourselves that this expression should not be unwelcome.

"C. B. M."

Rare indeed is the hospital where such a letter would be unwelcome.—*Ed.*

Abuses Widespread

Sirs:

The American Medical Association has made rather persistent effort to secure correction of the abuses referred to in the editorial ("Counter Prescribing at Its Worst," April issue.—Ed.) and in the article by Rebekah F. Dunning, and this effort has been maintained for a long time. I sincerely hope that your added effort will help to hasten a full realization of the desired ends. . . .

OLIN WEST, M.D.,
Secretary and General Manager.

American Medical Association,
Chicago.

Sirs:

I have read with great interest the editorial and paper dealing with the uncontrolled sale and prescription of apparatus for the treatment of orthopedic and surgical conditions. I heartily endorse all of the opinions expressed in both articles and I wish that they could be made stronger. The abuses mentioned are so widespread and so prevalent that the solution will be forthcoming only after many such attacks. The medical profession, itself, is not above criticism and responsibility in creating the present situation, for it is not uncommon to have physicians turn over the apparatus part of their work directly to the bracemakers for supervision without any instructions.

Some of the hospitals have attempted to install brace shops but have fallen into the error of modeling their service and the manufacture of apparatus along the lines now used by the commercial manufacturer. The fact that a piece of apparatus should be prescribed with the same degree of accuracy and intelligence that is necessary for a prescription of medicine seems to have fallen into complete oblivion. . . .

FREMONT A. CHANDLER, M.D.,
Secretary.

Section on Orthopedic Surgery,
American Medical Association,
Chicago.

Sirs:

The (Dunning) article calls attention, of course, to the necessity . . . of having a reliable concern take care of the brace work that is used in the orthopedic service of the hospital. As a matter of fact, most hospitals having a large orthopedic service have their own brace shop and are able to maintain it through its earnings. It pays a hospital of 200 or 300 beds to have a shop of this sort and to secure a competent bracemaker to operate it.

A similar hospital having only occasional orthopedic cases would do well either to arrange for its brace work with some shop connected with an orthopedic hospital, or to send all of its brace work to some of the more reputable manufacturers.

In all probability the hospitals that would be affected through the system that Miss Dunning complains of—and in which she is undoubtedly right—would be so few that it would not justify an editorial on the subject.

BERT W. CALDWELL, M.D.
American Hospital Association,
Chicago.

Sirs:

I ventured to refer Miss Dunning's article on commercial corrective appliances, and your editorial to Dr. Frank R. Ober, one of our well known orthopedic surgeons, for his consideration and I find him quite in accord with the necessity for action in this matter. I shall be glad to submit the idea to the Board of Regents of the American College of Surgeons at their next meeting. . . .

ROBERT B. GREENOUGH, M.D.,
President.

American College of Surgeons,
Boston.

Sirs:

. . . I think the statement of facts contained in the article by Miss Dunning is quite true. The editorial, of course, I agree with.

The problem of concerting any control over these matters is one that is attended with a great deal of difficulty. However, I do feel that your efforts are worth while.

R. K. GHORMLEY, M.D.,
Secretary.

American Orthopaedic Assn.,
Rochester, Minn.

Sirs:

I have read with interest both your editorial comment and the article by Miss Dunning. I agree that the situation is largely as described. Whether, however, it is the most serious problem still unsolved by the medical profession is questionable. This does not, however, invalidate the article as a whole. It is a timely discussion of one of the many hazards with which democratic America has been forced to contend.

R. C. BUERKI, M.D.,
President-Elect.

American Hospital Association,
Madison, Wis.

Sirs:

The article of Rebekah F. Dunning and your editorial are certainly very pertinent and I sincerely trust that steps can be taken to correct an abuse which is far more widespread than most of us have any idea.

ROBERT JOLLY, President.

American Hospital Association,
Dallas, Tex.

Boston Council Elects Dr. Howland President

The Hospital Council of Boston, formed to facilitate cooperation between hospitals and other agencies connected with health and social problems, at its meeting on March 11 elected Dr. Joseph B. Howland, superintendent, Peter Bent Brigham Hospital, president of the organization, Ingersoll Bowditch, vice president, and Dr. Charles F. Wilinsky, superintendent, Beth Israel Hospital, secretary-treasurer. Dr. Nathaniel W. Faxon, superintendent, Massachusetts General Hospital, is chairman of the executive committee.

Hospitals that have become members of the council are Beth Israel Hospital, Boston City Hospital, Boston Dispensary, Boston Floating Hospital, Carney Hospital, Channing Home, Children's Hospital, Collis P. Huntington Memorial Hospital, Faulkner Hospital, Florence Crittenton Home and Hospital, House of the Good Samaritan, Infants' Hospital, Long Island Hospital, the Massachusetts Eye and Ear Infirmary, Massachusetts General Hospital, Massachusetts Memorial Hospitals, Massachusetts Women's Hospital, New England Deaconess Hospital, New England Hospital for Women and Children, Peter Bent Brigham Hospital, Robert Breck Brigham Hospital, St. Elizabeth's Hospital, Evangeline Booth Home and Hospital and Roxbury Hospital.

Reorganize Courses in Nursing

Courses leading to the bachelor of science degree in nursing are being reorganized at Duquesne University, Pittsburgh. Carolyn E. Gray, formerly head of the Homeopathic Medical and Surgical Hospital and Dispensary school of nursing, will direct the reorganization.

Clinton Hospital Changes Hands

Clinton Hospital, Clinton, Okla., has been purchased by the Baptists of Western Oklahoma. The hospital, owned and operated by Dr. McLain Rogers for more than twenty years, will be known as the West Oklahoma Baptist Hospital and Nurses' Training School. J. G. Price of Mangum has been appointed superintendent and business manager. Doctor Rogers will remain with the hospital as chief of staff, but will have no other connection with the institution. The institution will be entirely nonsectarian. The corporation which will own the hospital will be nonprofit sharing and proceeds will revert to the hospital.

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Hospital Literature in Abstract

Conducted by E. M. BLUESTONE, M.D., Montefiore Hospital, New York City

Making the Physical Therapy Department Successful

It has been found that the successful operation of hospital physical therapy departments depends on proper direction, personnel and equipment, easy accessibility for all patients in the hospital, and cooperation of the medical and nursing staffs.* They should be reference departments, with responsibility vested in a director, qualified in both physical therapy and general practice, to permit the admission of patients to the hospital, in exceptional cases, under his immediate care. The three obstacles in the path of successful operation are the director without comprehensive training in all phases of physical therapy, a lack of cooperation or interest on the part of the medical staff and a tactless or careless personnel.

*Kovacs, Dr. Richard: Place of Physical Therapy in Organization of a General Hospital, Arch. Physical Therapy 15: 685, 1934. Abstracted by M. Hinenburg, M.D.

Reducing the Maternal Mortality Rate

Bradford* states that the small general hospital can reduce maternal mortality by establishing itself as a maternity center with a well supervised antenatal clinic and an efficient segregated obstetrical department.

The need for prenatal care is emphasized by the fact that about 33 per cent of the women delivered in North Carolina, South Carolina and Virginia are attended by midwives and receive little or no antenatal care. The mortality rate of the hospitals operating under the Duke Endowment in North and South Carolina is three times that of the state mortality of Virginia and North Carolina because of the admission of neglected cases. In hospitals where Negro patients are treated the rate is even higher, because 70 per cent of the women delivered by midwives are of the colored race.

According to the report of the British Ministry of Health based on a study of 2,000 maternal deaths, lack of prenatal care was the cause of maternal mortality in 35 per cent of the cases. Statistics reveal, in addition, that the maternal mortality rate in a well organized maternity center is half that in the general community. In North Carolina, 41.3 per cent of the deaths were due to toxemias of pregnancy and 75 per cent of these were ill when first seen by a physician. It is therefore felt that the organization of prenatal clinics for indigent and midwife cases aided by civic or welfare funds and under the supervision of a hospital staff would result in early recognition of complicating pathologic conditions of pregnancy.

The author points out that in the case of Mercy Hospital, Charlotte, N. C., the morbidity was diminished by 40 per cent when a separate maternity pavilion was opened. It is therefore recommended that the hospital limit the possibilities for puerperal infection within its own walls by obstetric segregation, isolation of infection, meticulous delivery room and postpartum technique and thorough asepsis. Finally, conservative obstetrics must be encouraged, vaginal examinations limited and blood transfusions made readily available.

*Bradford, Dr. W. Z.: The Rôle of the Small General Hospital in the Reduction of Maternal Mortality, South. M. J. 27: 1044-1047, 1934. Abstracted by Seymour Wimpfheimer, M.D.

Sterility of Surgical Catgut Sutures Questioned

The author* cites the work of Meleney and Chatfield, who devised an effective test for the sterility of catgut, and suggests that some controlling authority enforce adequate sterilization through an examination of specimens from every sterilized batch of material made by every manufacturer.

The author tested sixty-five lots comprising 6,184 sutures from twelve manufacturers over a period of five consecutive years in order to determine the practical value of the Meleney test. He added three control methods and special neutralizing solutions to the test in order to make it more efficient, and his results show that out of twelve products only two were found to be consistently sterile over a period of five years.

In Great Britain the Therapeutic Substances Regulations prescribe a test which must be undergone by specimens from each lot of catgut marketed. Although the test prescribed is not sufficiently accurate to reveal organisms in chemically treated catgut, Great Britain at least has recognized the need of control of sterility of catgut sutures.

The author feels that American manufacturers are using inadequate tests for sterility; that nonsterile catgut is being marketed in large quantities, and that adequate control of some recognized authority on the sterility of surgical catgut sutures is greatly needed in the United States.

*Clock, Dr. Ralph Oakley: The Present Status of the Sterility of Surgical Catgut Sutures with Particular Reference to American Made Catgut, Surg. Gynec. Obst. 60: 202, 1935. Abstracted by Arthur H. Aufses, M.D.

Health Insurance Criticized

The author advocates hospital sickness insurance under proper safeguards and strongly opposes voluntary or compulsory sickness insurance on a general scale, although conceding that in selected communities, under special conditions, it may be adapted to local needs.*

Sickness insurance does not place the burden of responsibility where it belongs, he says. It over-assesses the greater proportion of the population who can least afford it for the special benefit of the few. He points out an apparent fallacy in the conclusions of the Committee on the Costs of Medical Care which calculates the average cost of medical care in the United States at $30 per person. The author states that the more correct figure is about $11.50 per person.

According to the findings of the committee, 50 per cent of the estimated total cost of medical care is for hospital care, which is for only 10 per cent of the population. Moreover, $485,000,000 of the total $3,656,000,000 spent for medical care goes for patent

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medicines or the services of cultists, and, he thinks, should not be included in the total. By eliminating these two items, a much smaller amount, $1,343,000,000, remains chargeable to general medical care for 90 per cent of the people. Thus, the average cost for the 90 per cent is reduced to almost a third of the average cost for everybody, while in the plans for general health insurance based on the committee's estimate the assessment per person exceeds $30. Furthermore, these plans cannot be carried out without government subsidy.

The author contends that hospital sickness insurance under the safeguards established by the American Hospital Association would place the greatest part of the burden where it rightfully belongs, on those who incur the greatest expense.

The practice of medicine under a general insurance scheme, he says, will unfavorably affect the personal relationship between physician and patient. He advances the following arguments against health insurance.

1. That group practice, which will be an inevitable result, cannot be satisfactory. It will be destructive of the quality of medical service and the economic status of the physician.

2. Insurance systems have not been a success in European countries.

3. Physicians besought on the one hand by the insurance authorities to reduce costs, and on the other hand by the demands of patients who appear to need attention or who are greedy about getting their money's worth, will be placed in a dilemma which will react unfavorably upon the service.

4. Individuals with minor or unimportant diseases, malingerers and the like, may crowd out patients who really need attention.

5. Provision of such benefits without adequate effort on the part of the beneficiary is detrimental to character.

6. The method of distributing the cost under these plans is contrary to the time-honored custom of assessing the highest income groups for the care of the less fortunate. Since persons earning above $5,000 do not come within the scope of the measures at all, he argues that the burden of carrying the poor will be placed mainly on the middle class, who are least in a position to meet it, and the majority of the wealth of the country will escape responsibility, except for the minimum to be contributed by the government from tax funds.

*Martin, Dr. Walter B.: Insurance, Hospital and Sickness, Virginia Med. Monthly, Jan. 1935. Abstracted by Alice E. Paulsen.

Physical Therapy in Disfavor in California

Physical therapy in California is in disfavor with patients, physicians and insurance carriers because of its exploitation by quacks, charlatans and other parasitic cults.* Gaining recognition as a specialty after long delay, it has failed of its purposes in many cases as a result of faulty diagnosis, improper administration of its therapeutic measures and gross ignorance and negligence on the part of untrained technicians. Other factors responsible for the debased status of physical therapy are listed by the author as follows:

(1) Many chronic patients are selected for physical therapy merely because all other medical measures have failed. (2) The error of considering physical therapy a cure-all, when it is really only an adjunct to medicine and surgery is a common one. (3) Too many physicians engage physical therapy technicians for commercial gain only. (4) Sales of worthless apparatus to gullible physicians by dishonest high pressure salesmen are numerous. (5) Ignorant laymen can secure, without difficulty, all kinds of physical therapy equipment. (6) There are no statutory restrictions in California prohibiting any nonmedical individual from practicing as a physical therapist. (7) The medical profession is careless in selecting physical therapists for their patients. (8) Medical schools fail to include an adequate course in physical therapy in their curriculum. (9) Scientific contributions to the literature are limited. The blame may be placed almost entirely upon the medical profession.

Under the laws of California anyone may purchase physical therapy equipment or x-ray apparatus and can be prosecuted only if it can be proved that he treated a diseased condition. It has proved almost impossible, however, to secure convictions. A committee on physical therapy of the state society exists "to make a survey of institutions and equipment, to promote teaching, to investigate establishments, to encourage presentation of papers and distribution of literature," but the solution can come only through legal regulation under power to examine and to license. Other states, like New York State, Ohio and Minnesota, have medical practice acts governing physical therapy in its different activities.

Physical therapy is fundamentally sound as an integral part of medicine and should be subjected to legislative control. If the practice of physical therapy is permitted to remain in the hands of quacks instead of in those of honest, well trained physical therapists who might legalize it under their control, the patients will be the victims. Medicine will be properly served by placing physical therapy technicians under the control of the state board of medical examiners.

*Behneman, Dr. H. M. F.: Physical Therapy—Criticisms and Suggestions, California & West Med. 41: 393, 1934. Abstracted by M. Hinenburg, M.D.

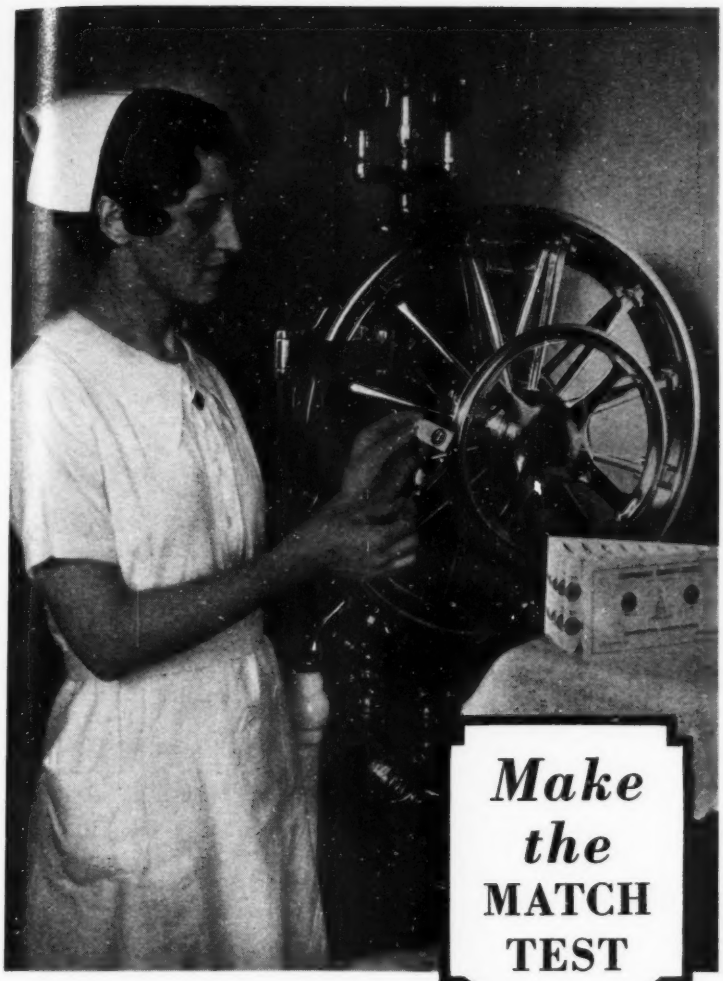
British Health Insurance and the Medical Profession

McCleary* states that the British medical profession was not consulted about the National Insurance Act when it was originally introduced in Parliament.

At the insistence of the profession, however, the act was radically altered to embody the following provisions considered essential by the profession: (1) the separation of medical services from the administration of cash benefits, although insurance physicians in England still have the responsibility of certifying disability to enable workmen to obtain their cash benefits; (2) the right of every legally qualified physician to undertake insurance practice if he wished; (3) free choice of physician by patient, subject to the physician's consent; (4) effective participation of insurance physicians in the administration of the system; (5) choice by the insurance physicians of any area of the method of medical remuneration in that area.

The British Medical Association believed that these objectives could best be obtained through use of the panel system. The panel system is not synonymous with insurance medical practice nor with any particular method of payment. Payment at so much per person is now universal in England although for twelve years panel physicians in two areas were paid at so much per call. Insurance physicians participate effectively in the administration of the system at every level and their influence is profound and far-reaching. The article states that "it is largely for this reason that the system is accepted by the general body of the profession as a satisfactory method of providing medical care for those who are unable, unaided, to pay for the medical services they need."

*McCleary, Dr. George F.: The Influence of the Medical Profession on the English Health Insurance System, Milbank Memorial Fund Quarterly, Jan., 1935. Abstracted by Alden B. Mills.



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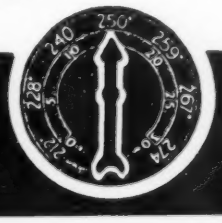

A·T·I·

Producing Artificial Hyperthermia

The authors* assume, on the basis of their clinical experience and laboratory experiments, that therapeutic fever is effective because of the thermal death time which is necessary to bring about the death of the infective agent, and that it makes little difference which method is used, provided it can be controlled. The clinical control of the patient is similar for all methods of producing fever.

The treatment room must be equipped to meet all requirements. The installation of the apparatus requires a control box with a number of outlets and the necessary rheostats and meters. A diagram of a treatment room indicating the dimensions of the room, as well as the location and size of the equipment, is one of the important illustrations in the article.

The first method used is diathermy. The diathermy unit, with a frequency of 1,000 kilocycles (300 meters) and an available current of 5-6 amperes, is applied to the trunk of the patient by large block tin electrodes. The cabinet used is a shallow wooden box containing a rubber covered mattress. A lightweight box secured to a wooden frame is hinged to the box, and fits snugly around the mattress when closed. The box is provided with eight 60-watt carbon filament lamps, controlled by a rheostat to compensate for the patient's heat loss, as well as to maintain the temperature after the electrodes are removed. The head of the patient protrudes from the box. Doors and windows in the box permit adequate supervision of the patient.

The second method used is radiothermy. This requires two 500-watt radio transmitting tubes, oscillating at a frequency of about 10,000 kilocycles. In this method, the patient is first placed on a stretcher, instead of on a mattress, on the oscillator housing so that he is in the electrostatic field between large protected plates. In a more recent set-up, the cabinet is apart from the oscillator. Within the double walls of the cabinet are placed aluminum plates 25 cm. x 130 cm. x 1.5 mm. connected to high voltage terminals. Beneath the stretcher are several resistance type heaters (in place of the heat lamps employed for the first apparatus). At the other end is a semi-rigid rubber hose connected to an exhaust fan, which permits hot air to be drawn about the patient and humid air to be removed from the cabinet.

The third method, radiant energy, after considerable experimentation, was set up to apply the infra-red and visible radiation to the skin over a large area. Five 200-watt heating lamps in reflectors, were used to irradiate the trunk and lower extremities. These units were all controlled by rheostats.

The first method (diathermy) is costly, and if electrodes should be loosened through movements of the patients, potentially dangerous.

In the second method the patient is not restrained, as he is in the first method, by the directly applied electrode. Treatments are more time consuming and cumbersome. Frequent temperature observations that are difficult to make without interrupting the treatment, are necessary in this method.

The heat transfer in the third method is more rapid than in the other methods since the blood in the large capillary bed of the skin is readily heated by the application of radiant energy. Temperature elevation is almost immediate, the rise is uniform and ceases when radiation is discontinued. There are no violent fluctuations of temperature. Radiant energy eliminates the danger of burns except those that may occur through accidental contact with the lamps, or through some part coming too close to the lamps. The heat loss due to evaporation of sweat and other causes is prevented by the adequate reserve of energy.

In an extensive series of treatments to more than 300 patients the authors have reached the opinion that the radiant energy method is the most convenient and economical.

*Bishop, F. W.; Lehman, Emmy, and Stafford, Dr. L. Warren: A Comparison of Three Electrical Methods of Producing Artificial Hyperthermia. J. A. M. A. 104:910, 1935. Abstracted by I. M. Leavy, M.D.

Sane Treatment of the Mentally Ill

In his introduction, the author* points out that although hospitals for the mentally ill were formerly thought of purely as asylums where patients were locked up to remove them from society, the advance of the science of medicine has changed this attitude so that these institutions have become hospitals where mental patients can receive proper treatment.

The accepted causes of psychoses are listed as well as the classification of the psychoses set up by the American Psychiatric Association. It is pointed out that while the population increase has been approximately 16 per cent, mental diseases reported by hospitals show a numerical growth of 66 per cent.

With this tremendous increase there is the inevitable overcrowding of mental institutions, which has become so marked that in some instances hospitals have had to carry twice as many patients as their rated capacity. The author suggests that in order to check the increase in the number of mental patients, treatment will have to be directed toward removal of all sources of infection and the practice of proper dietetics and hygiene. He stresses as specific therapy the use of hydrotherapy, occupational therapy, arsenicals along with malaria treatment and diathermy, the sedatives, especially the barbitals, and, finally, proper surgical treatment, such as is used for the removal of a cicatrix in epilepsy. He also advocates sterilization of mental defectives and the incurably insane where two or more generations have shown evidence of being afflicted with a similar disease.

The West Virginia plan of treatment of the situation as a whole is outlined. The state authorities intend to establish a receiving center for all mental patients from the entire state, where they will be given complete medical, surgical, dental and psychiatric study. From this receiving center the patients will be sent to other institutions in the state for further care and therapy.

*Offner, Dr. J. E.: Sane Hospitalization and Treatment of the Insane. W. Virginia M. J. 30:534, 1934. Abstracted by B. H. Balser, M.D.

A Correction

In last month's issue an abstract of the paper by Weeden B. Underwood on "Scientific Analysis of Steam as Used in Sterilizing" stated that "the temperature necessary for successful sterilization is 259-267 degrees which is equal to 20-25 pounds pressure for a sufficient period of time to allow penetration to the center of the material."

Actually these figures are higher than those stated by Mr. Underwood, who declared: "We now have authoritative published statements available which show that steam at 10 to 15 pounds pressure, maintained for a comparatively brief interval of time is sufficient for surgical sterilization. This, of course, limits the possible temperature within the range of 240°-250° F." Recent further tests, shortly to be published in The MODERN HOSPITAL, substantiate these findings.

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The U. S. standard of weight is Kilogram No. 20, a cylinder composed of 90% platinum and 10% iridium. It rests on a quartz plate and is sealed under double glass bells. This kilogram is handled only on rare occasions and then only with special chamois-faced forceps. Every precaution is taken to guard it against wear. All weights in the United States and territories are compared indirectly with this primary standard.

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. . .

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BOOKS ON REVIEW

HEALTH DENTISTRY FOR THE COMMUNITY. *By the Committee on Community Dental Service of the New York Tuberculosis and Health Association. Chicago: University of Chicago Press,* 1935. *Pp.* 85. $1.

This slender book is historic. It represents, so far as this reviewer knows, the first attempt of any dental group to analyze carefully all the available significant data about the prevalence of dental diseases and defects and the distribution of dental services, and to formulate a broad scale program for providing dentistry to the whole community.

The committee, under the chairmanship of Alfred Walker, D.D.S., concludes that only a small percentage of the population now receive adequate dental service either from private practitioners or dental clinics. The members are almost but not quite appalled by the size of the problem faced in trying to give care to adults who have neglected their teeth. Even at very low rates it would cost an average of $86 a person to do the minimum amount of work for such adults necessary to put their mouths in satisfactory shape. Start with the children, they suggest, at the age of two.

The committee criticizes the reports of the Committee on the Costs of Medical Care for not more clearly differentiating dentistry from medicine and child dentistry from dentistry for adults. Nevertheless their recommendations harmonize with those of the C. C. M. C.

It recommends that the first step be complete dental service with major emphasis on prevention, furnished presumably by the schools or some other state agency, for all children from the age of two onward; that the curative treatment of oral disease in adults be given second place, and that the restoration of the organs of mastication by means of artificial teeth should have third place. It claims that large savings will result to the schools from the prevention of dental defects and diseases through the reduction in absences and failures. Health insurance, the committee holds, can be devised in such a way that it will minimize the disadvantages found in European plans and embrace the advantages.

While recognizing the possible future value of present experiments on the dietary control of caries, the committee points out that such measures even if found to be scientifically sound will not solve the problem because of the slowness with which food habits are changed.—ALDEN B. MILLS.

NUTRITION. *By Margaret S. Chaney, Ph.D., and Margaret Ahlborn, M.S. Boston and New York: Houghton Mifflin Company,* 1934. *Pp.* 436. $3.

An addition to the Riverside Home Economics Series edited by Alice F. Blood, Ph.D., Simmons College, this book is planned for teaching of nutrition to college and normal school students, but the dietitian will find in it good suggestions for teaching nurses.

The material is so arranged as to meet the needs of the student who wishes to use it professionally and for the one who desires a knowledge of the science of nutrition in order to adjust her life and that of her family to the standard for healthful living. Therefore, only a minimal background of organic chemistry and physiologic chemistry is required.

Laboratory exercises and a bibliography follow each chapter, good photographs and charts throughout the book and Mrs. Waller's excellent table add further value.—LULU G. GRAVES.

NEWS FROM MANUFACTURERS

Additions to the Family of X-Ray Screens

The Patterson Screen Co., Towanda, Pa., marks its twenty-first anniversary in the production of x-ray screens by introducing two new types. Advance literature on the Patterson Detail Intensifying Screens reports that these are for use in cases where ultimate detail is of utmost importance. It is stated that radiographs formerly made without screens in order to preserve detail, now can be made in very much less time.

The Fluorazure Intensifying Screens are specialties extremely fast in the lower kilovoltages, we are told, and utilize a new chemical to be known as Fluorazure, based on an application of zinc sulfide. The factor of speed, of paramount importance in heart, chest and similar types of work, is due to the ability of zinc sulfide to convert more of the invisible x-ray energy into photographically effective light, it is stated.

Light and Sight With This Bedside Lamp

The "Sands Bedside Illuminator" is pronounced a 1936 model for 1935, by Sharp and Smith, Inc., 65 East Lake Street, Chicago. A twist of the metal shade, and this all-purpose light is converted into an examination lamp for the doctor who may be changing dressings, with direct light flooding exactly where required. Another twist, and it provides a soft, indirect illumination for the room in general. Or, the shade is turned down to afford a glareless light for reading.

This illuminator is found to be practically no more expensive than ordinary bedside lamps, the manufacturer states.

Nonspill Spoons Outwit Their Opponents

Visualize a spoon, where the part of the bowl nearest the handle is covered or capped, and you have a picture of the new feeding and medicine spoon developed by Edward Weck & Co., Inc., 135 Johnson Street, Brooklyn, N. Y. By holding this device upright, the contents may be hidden from child patients who object to taking their castor oil or medicine in general.

Since orange juices, oils and medicines may be given the adult or child patient in any position in bed, the staining of blankets, bed linens and clothing is eliminated, the manufacturer informs us.

Oil for the Stoves of Hospitals

A new line of cooking equipment designed for hospitals, sanitariums and other institutions where large scale cooking operations are carried on is offered by the Motor Wheel Corporation, Lansing, Mich.

Both oil burning cooking ranges and bake ovens are included in the line and, in addition to high standards of cooking performance, they are claimed to afford large savings in fuel costs. Burning ordinary No. 1 fuel oil or furnace oil, these ranges and bake ovens are characterized as being fast, clean and odorless. Their construction, it is claimed, is such as to give a uniform temperature distribution both in the ovens and on the French type cooking tops.

The burner employed is of the natural draft type. It

has no moving parts, and a convenient oil control enables the user to adjust the burner to any desired temperature at a moment's notice. In addition to affording savings in fuel costs, these ranges and ovens are said to offer savings in food shrinkage, as a result of the use of an unvented oven.

The oil burning bake oven is offered in a four-tray size with a capacity for forty-eight 1½-pound loaves of bread or twenty-four 10-inch pies; while the range units are available in a number of different sizes designed to meet every type of requirement up to the largest size hospital. Both the ranges and ovens may be installed in ba[illegible] of two or more where a total capacity of this ext[illegible] required.

Painless Adhesive-Removal Versus "Quick-Ripping"

Why add to a patient's sea of troubles by resorting to the old method of ripping off the adhesive? A new and painless method, suggests The Harrington Research Corp., Buffalo, N. Y., is to apply Adhesol, a solution which is said to dissolve all the adhesive compound on the tape, freeing skin and hair alike. A corner of the tape is lifted, the solution is swabbed along the line of adherence, and the adhesive peels off as one proceeds. This solution is claimed to be both nonirritating and noninflammable.

A Speedy New Robot Is This Wall Washer

The Cleanwall, made by Cleanwall Mfg. Co., 105 West Adams Street, Chicago, makes a bid for that herculean task, the smooth, streakless washing of walls and ceilings. It is a compact, lightweight unit of two copper tanks, one filled with cleaning solution, the other with clear water. Forced from the tank by means of a hand pump, the cleaning fluid is applied with a trowel covered by a cloth pad. A second trowel, also cloth covered, rinses off any dirt and cleaning solution that remain. No dripping and splashing, it is stated, are apparent in the process. It is also said that wall paint is preserved, and the luster renewed.

A Portable Cautery Unit Makes Its Debut

Max Wocher & Son Co., 29 West Sixth Street, Cincinnati, introduces a portable electro-surgical unit designed to give the ease of control which is a feature of this company's Majestic Hospital Unit. The latter is a device for cutting and electro-coagulation, and is said to be outstanding in the field of cautery.

Housed in a leatherette case, the new unit is not only featured for its portability, we are told, but is adaptable for all office procedure in which electro-surgery is indicated, as work with tonsils, turbinates, warts, moles and growths.

The Aero-Tent Competes With Tom Thumb

With a weight of but 90 pounds, this recently developed motorized oxygen tent goes into the tonneau of any small car, states The Heidbrink Company, Minneapolis, and is adapted to aeroplane transportation. We are told that it is quickly folded into condensed size, at the same time retaining all features demanded by the therapist for successful oxygen therapy.

Any nurse, it is further stated, can, without assistance, perform the duties incident to the movement, adjustment, mechanical operation and practical application of the No. 55 Aero-Tent.

New Trade Catalogues and Pamphlets

First-Aid for Adventurers—The romance in the life of a medicine kit is depicted in a little red and silver volume newly published by Burroughs, Wellcome & Co., Inc., 9 East Forty-First Street, New York City. This gives the high spots of great explorers' adventures, from Sir Henry Stanley to Admiral Byrd, and explains how the "Tabloid First-Aid Kit" has been utilized for more than half a century by explorers, flyers and other adventurers. Also included are descriptions and illustrations of "Tabloid Emergency First-Aid for All Climates."

Noise Fighters—Research engineers in the laboratories of Johns-Manville, 22 East Fortieth Street, New York City, feel that there's entirely too much noise in the world. How they attack clangor and din is told in a new booklet presenting significant developments made in acoustical science.

A Word to Physiotherapists—He who reconnoiters for new and improved physical therapy and electro-surgical equipment may profitably study the new catalogue of The Burdick Corporation, Milton, Wis. All apparatus, from ultraviolet lamps to bath cabinets, is carefully described and the numerous illustrations speak for themselves. A folder is also included on the Burdick Short Wave Diathermy Unit.

X-Rays Almost Think for You—More evidence of how radiographs corner those elusive symptoms and help to build up an accurate diagnosis is offered in a new publication by Eastman Kodak Co., Rochester, N. Y. Large illustrations show how x-rays detect fractures previously unsuspected or how they reveal sources of chronic infections. This company also publishes "X-rays and Health" which is directed to the layman.

Modern Maintenance—Cleanliness around the hospital is no longer a matter of the scrub bucket and a strong right arm; it is apparently a science. A booklet recently issued by The Hillyard Chemical Co., St. Joseph, Mo., displays a wide and varied line of cleaners, disinfectants, soaps and other sanitation supplies and includes many pages devoted to floor maintenance materials and the machines used to apply them.

Touring by Proxy Through a Paper Mill—Logs jammed in the river, pulp bales just off the boat from Finland, a giant machine which is said to make 250 miles of paper tissue per day—these are high spots in the sizable new book issued by Scott Paper Co., Chester, Pa. Lured by picture and prose descriptions, the reader wanders through pages telling this story of paper making. Care, it is explained, is taken to produce a clean, soft, absorbent and sanitary paper.

University of Chicago Press—"Economies in Food" is the title of a helpful little booklet of about fifty pages that has been published by the University of Chicago Press, Chicago. The booklet contains quantity recipes using evaporated milk. The authors are M. Faith McAuley and Mary Adele Wood.

Make a Clean Sweep With Soap—"What Are Your Soap Requirements?" asks Procter & Gamble, Cincinnati, in a booklet recently received. Listing a whole battalion of products, they suggest a soap for every cleansing need. This charge of the soap brigade also leads to the hospital laundry with such booklets as "Longer Life for Your Linens" and "Salvaging Linens by Stain Removal," worked out by the laundry research department of this company.